The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee
AGENDA

Meeting Details

Date Thursday 22nd July 2021
Time 09.00 – 11.00
Location Via MS Teams – to be live streamed to the public

AGENDA

Item No.	Agenda Item	Paper / Verbal	Lead	Required Action	Time
2021/35	Welcome and Apologies	Verbal	Chair	Noting	09.00 (15 min)
2021/36	Declarations of Interest relevant to agenda items	Verbal	Chair	Noting	
2021/37	Minutes of meeting of : 27th May 2021 (as amended) 24th June 2021 Matter Arising	Enc 1.1 Enc 1.2	Chair	Approval	
2021/38	LAFL Theme 3 Obstetric Anaesthesia	Presentation	Dr Lorien Branfield, Lead Consultant Obstetric Anaesthetist Others tbc	Discussion	09.15 (60 mins)
2021/39	Observations and comments from relevant stakeholders and groups representing service users • What have the stakeholders and groups representing service users heard so far in the first four meetings? • What reflections and observations do they have and wish to share at this stage? • Based on where the work of the Committee so far, what would stakeholders wish to see in the future meetings relating to the Ockenden Report action plan?	Verbal	Chair All	Discussion	10.15 (15 min)
2021/40	Discussion and reflection • Key messages for the Board of Directors • Key messages for service users - women and families • Any other steps we need/wish to take	Verbal	Chair All	Discussion	10.30 (15 min)
2021/41	Meeting closes NO AUGUST MEETING Date of Next Meeting: 23rd September 2021	Verbal	Chair		Finish 10.45

Possible Items for Future Meetings (subject to change)

Formal business items

Further review of Ockenden Action Plan progress – 23rd September 2021

Emerging related themes

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

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

Thursday 27th May 2021 via MS Teams

Minutes

NAME	TITLE	ITEM
MEMBERS		
Dr C McMahon	Co-Chair	
Ms J Garvey	Co-Chair	
Professor T Purt	Non-Executive Director (Trust) and Chair of Audit & Risk Assurance Committee	
Mr A Bristlin	Non-Executive Director (Trust) and Non-Executive Director Lead for Maternity Services	
Mrs L Barnett	Chief Executive (Trust)	
Ms H Flavell	Director of Nursing (Trust)	
Mr N Lee	Chief Operating Officer (Trust)	
Ms Z Young	Director of Nursing & Quality, Shropshire, Telford & Wrekin CCG and Local Maternity & Neonatal System	
Mr J Jones	Acting Medical Director	
Ms V Barrett	Chair, Healthwatch Shropshire	
Mr B Parnaby	Chair, Healthwatch Telford & Wrekin	
Dr 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 G Calcott	Consultant Obstetrician & Gynaecologist	
Mr M Wright	Programme Director Maternity Assurance (Trust)	
Mr T Baker	Senior Project Manager Maternity Transformation Programme (Trust)	
Mr R Kennedy	Regional Associate Medical Director	
Ms T Hymas-Taylor	Head of Safeguarding, Representing Chief Nurse, Sherwood Forest NHS FT	
Mr K Haynes	Independent Governance Consultant	
Ms A Kerr-Gold	Executive Assistant	
APOLOGIES		
Ms F Ellis	LMNS Programme Manager	
Ms L MacLeod	Maternity Voices Partnership Development Coordinator Telford & Wrekin	
Ms J Hogg	Chief Nurse, Sherwood Forest NHS FT	
Ms L Cawley	Health Watch	
Ms Nicola Wenlock	Director of Midwifery (Trust)	
Ms J McDonnell	Divisional Director of Operations Women & Children (Trust)	
Ms A Milanec	Director of Governance & Communications (Trust)	
Dr A Rose	Medical Director (Trust)	
Ms E Evans	Maternity Voices Partnership	

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

023/21	**Exception Reports for overdue deliverables** ***1- Ockenden action 4.65: 'where the maternity service must appoint a dedicated lead Midwife and lead Obstetrician, both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.***' Mr Calcott explained that he was leading this particular action and would speak to the associated exception report. Mr Underwood and Dr Hon would speak the remaining three exception reports. He explained that whilst bereavement care is currently given by the staff directly involved in a women's care, this requirement is for the appointment of both a midwife and obstetrician with demonstrable expertise and skill in this area, to further improve the Trust's bereavement services. It was noted that the Lead Midwife was already in post. The current delay, accounting for the exception report, is due to the prepared and locally approved business case awaiting consideration and approval at the Integrated Care System. Mrs Barnett agreed to pursue the matter with the system at pace as it is not directly within the Trust's purview to approve this, and related maternity service requests for additional expenditure. Mrs Barnett agreed to provide an update to the next meeting of the Committee. Mr Calcott also explained that there are plans to set up a Rainbow Clinic or a Rainbow Service and that the lead for bereavement care, along with himself, would be instrumental in developing this service. This service will be offered to women who have experienced bereavement in the past, to support them through a future pregnancy. ***2- Ockenden Action 4.98: "There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care."*** Mr Martyn Underwood explained that this action was currently off-track because further guidance was being sought as the Ockenden report recommendation was not directly aligned with current national practice, based on the guidelines of the British Association of Perinatal Medicine (BAPM). He went on to explain that this had been shared with the External Expert Advisory Panel and clarification has been sought from them. In response to a request for clarification from Ms Garvey, Mr Underwood explained that there is a very clear national framework detailing which babies should be discussed with tertiary referral centres, and there are exception reports each month to check for compliance. At present a smaller (e.g. Level 2 as at SaTH) neonatal unit would not speak to a tertiary centre about every baby if it had been able to stabilise the baby immediately and there had been clinical improvement. The Ockenden action requires the local neonatal unit to seek advice from the tertiary referral unit in relation to each baby who requires intensive care. Dr McMahon, the Co-Chair, asked for confirmation that the current level 2 neonatal unit is adequately equipped and staffed to care for babies who are 27 plus weeks, 800 plus grams and are stabilised once the initial resuscitation has been undertaken.	

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

3- Ockenden Action 1.6: "All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months."

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

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

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

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

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

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

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

occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

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

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

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

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

IEA 4: Managing Complex Pregnancies

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

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

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

audit.

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

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

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

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

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

IEA 5: Risk Assessment Throughout Pregnancy

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

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

IEA 6: Monitoring Foetal Wellbeing

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

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

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

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

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

IEA 7: Informed Consent

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

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

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

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

	In response to a question from Ms Garvey, Dr Hon confirmed she was happy with the pace of the progress so far. Dr McMahon seconded that whilst the plan is written in such a way that it doesn't look like a lot of work, one shouldn't underestimate the efforts and the workload involved to achieve these targets and deadlines. In support, Dr Richard Kennedy added that he felt that the performance metrics were tracking in the right direction based, he felt, on an excellent plan and team in place.	

025/21	**Q&A** 1. **"Will women be able to see their feedback on their notes and how they are presented, will there be checks that women understand them and find them useful. I encourage the Trust to consider those members of the population who have low literacy levels including the inability to read, disability or impairment and people for whom English is not their first language. It also goes without saying that digital exclusion is an issue at the moment and there should not be an over-reliance on electronic forms of communication."** Dr Hon confirmed that feedback and confirmation of understanding is part of the process. Notes will be available in electronic and paper form and can be translated into different languages. It is not yet known how many patients will opt not to use the digital format of notes, but BadgerNet has a function to print each of the documents to create a file for the lady. Mike Wright asked for an update on discussions with Ms Julie Hogg, Chief Nurse from Sherwood Forest regarding surveys of patient understanding (action from ORAC 1 discussion). In Julie's absence, Tina will take this action and request an update from Julie. 2. **Health Watch Shropshire asked about information sharing across county borders. "At Health Watch Shropshire we are particularly aware of this issue and how it affects women in the south of the county, e.g. Ludlow, who go on to have their baby in Hereford. Can you tell us the arrangements that are currently in place or planned?"** Martyn Underwood confirmed that Joy Payne, interm Head of Midwifery, has been in communication with Powys Health Board about this recently. BadgerNet will help to share information with adjacent hospitals on a read only basis. Currently, all information is in handheld records. With the rollout of BadgerNet, the Trust will be able to share information electronically with other hospitals that also access BadgerNet. Dr Hon added that the other aspect of this to consider is the referral pathways. Martyn Underwood explained that going forward with BadgerNet, the aim is that the patient will have access to all of their information on their electronic records which they can share with their GP in a read only mode. In addition, GPs will have access to BadgerNet, as in other units in the country that already have BadgerNet. If woman do not have access to, or prefer not to use, a handheld device, they will have a paper version of their notes. 3. **"If this goes above the NICE guidance will the trust be able to demonstrate adherence to what is included in the NICE guidance as well as FIGO?"** Dr Hon explained that there is no straightforward answer to this. The only point where FIGO is being used instead of the NICE intrapartum guideline is the section that details fetal monitoring. It is about the tool that is used to interpret the CTG and about whether to use straightforward pattern recognition or whether to move more into trying to explain what's going on physiologically with baby. SaTH is using what they consider to be a more inclusive way of interpreting CTGs by implementing FIGO and this is in line with a growing number of units across the country.	Action

4. **Health Watch Shropshire asked: "Health Watch Shropshire runs the independent health complaints advocacy service and Shropshire residents, those using NHS services in Shropshire, can you assure us that women and families involved in this process are given the opportunity and encouraged to ask their own questions that are then incorporated into any investigations and included in the feedback to women and families concerned. "**

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

5. **Health Watch Shropshire asked: "involvement of fathers and families. It sounded like their involvement is based on the consent of the mother, could it not be argued that as part of good public engagement they should have the opportunity to ask questions and have feedback in their own right. We have spoken to some fathers who have been shaken by their experience of childbirth and had questions.'**

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

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

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

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

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

6. **Health Watch Shropshire and Health Watch Telford and Wrekin jointly wrote formally to the Trust to ask questions about the availability of support for those families involved in the Ockenden enquiry, those using services now and previous/current staff working within maternity.**

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

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

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

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

Thursday 24th June 2021 via MS Teams

Minutes

NAME	TITLE	ITEM
MEMBERS		
Dr C McMahon	Co-Chair	
Ms J Garvey	Co-Chair	
Professor T Purt	Non-Executive Director (Trust) and Chair of Audit & Risk Assurance Committee	
Mr A Bristlin	Non-Executive Director (Trust) and Non-Executive Director Lead for Maternity Services	
Mrs L Barnett	Chief Executive (Trust)	
Ms H Flavell	Director of Nursing (Trust)	
Mr N Lee	Chief Operating Officer (Trust)	
Ms Z Young	Director of Nursing & Quality, Shropshire, Telford & Wrekin CCG and Local Maternity & Neonatal System	
Mr J Jones	Acting Medical Director	
Ms V Barrett	Chair, Healthwatch Shropshire	
Dr A Wilson	Member, Powys Community Health Council	
ATTENDEES		
Mr M Underwood	Divisional Medical Director for Women & Children (Trust)	
Dr M-S Hon	Clinical Director – Obstetrics / Maternity (Trust)	
Mr M Wright	Programme Director Maternity Assurance (Trust)	
Mr T Baker	Senior Project Manager Maternity Transformation Programme (Trust)	
Mr K Haynes	Independent Governance Consultant	
Mr D Burrows	Head of External Communications	
Mr G Calcott	Consultant Obstetrician & Gynaecologist	
Mrs B Green	Independent Specialist Midwife, Sherwood Forest NHS FT	
Mr R Kennedy	Associate Medical Director NHSE/I Midlands	
Mrs K Kirk	Operations Lead for Hospital COVID Vaccination Hub, Sherwood Forest NHS FT	
Mrs L MacLeod	Maternity Voices Partnership Development Coordinator Telford & Wrekin	
Ms L Reid	Lead Midwife for Saving Babies Lives	
Mr B Russell	Interim Head of Communications	
Mrs E Evans	Maternity Voices Partnership	
APOLOGIES		
Ms L Cawley	Health Watch	

No. 2020	ITEM	ACTION
Procedural Items		
029/21	**Welcome, introductions and apologies**. The Co- Chair, Jane Garvey welcomed all present including the public to the live stream of the meeting. Introductions were made and apologies were noted.	
030/21	**Declarations of Conflicts of Interests** There were no declarations of interest noted..	
031/21	**Minutes of the previous meeting and matters arising** Mike Wright gave an update on the queries raised around local actions for learning 4.98 and 4.99 in the previous meeting. Two points of clarity have been addressed and discussed with Mrs Ockenden and an update will be given by the end of the month. Zena Young suggested an amendment to the wording on page 16 of the minutes from the 27th May meeting with regards to Jane Garvey's comment about the involvement of Maternity Voices Partnership. She would like the sentence "they may need encouragement to do so" to be amended with "should be encouraged to present their work". Jane Garvey agreed to this amendment and arranged with Emily Evans from Maternity Voices Partnership to come and present their work in September.	
032/21	**Saving Babies Lives (SBL) – Care Bundle v2 Update** **Local Action for Learning 4.57** The Co-Chair, Jane Garvey started off by asking Lindsey Reid what the Saving Babies Lives initiative is all about. Lindsey Reid gave an overview and some background to the SBL's initiative and goals to be achieved. In response to a question from Jane Garvey, Ms Reid confirmed that the initiative had its origins in concerns about the country's comparative numbers of stillbirths and pre-term births. *Ockenden Local Action for Learning 4.57:* *"These leads [dedicated midwife and obstetrician] 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."* This care bundle is broken down into 5 elements: Element 1: Reducing smoking in pregnancy	

Lindsey Reid explained that there is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth. It also impacts positively on many other smoking-related pregnancy complications, such as preterm birth, miscarriage, low birthweight and Sudden Infant Death Syndrome (SIDS). Whether or not a woman smokes during her pregnancy has a far-reaching impact on the health of the child throughout his or her life.

8 standards are in place to achieve this. These include interventions and learning, covering CO testing and stop smoking support.

Lindsey Reid explained that the measures currently in place are:

- Appointment of public health midwife with specific role to reduce smoking in pregnancy since March 2017.
- Stop smoking service provided by Shropshire Council Public Health and Telford and Wrekin by SaTH Public Health Midwifery Service.
- CO screening for all women at every appointment since 2019 (exception during Coronavirus pandemic).
- Weekly telephone support, access to free nicotine replacement therapy and constant phone support if required.
- Mandatory training around stop smoking for maternity staff.
- Women can be referred to smoking cessation support service at any point in their pregnancy and are asked at every appointment if they wish to be re-referred by all healthcare professionals.

Lindsey Reid went on to present the future plans:

- Partial CO Testing resumed in March 2021 in line with Coronavirus protocols; data to be collected and presented to the Maternity Transformation Assurance Committee (MTAC).
- Stop smoking support during pregnancy is moving toward a single service across the county this year.
- The enhanced service will be based within SaTH and supported by the Local Maternity and Neonatal System and this 1st year by both County Councils.
- The service will offer a family approach to health promotion.
- Employ Badgernet (when available) to capture smoking status.

In response to a request for questions, Anthea Wilson asked whether the nicotine replacements also have an effect on the unborn baby. In addition, she questioned whether a smoking pregnant woman who claims to have quit smoking is quite willing to have her CO tested. Lindsey Reid explained that they usually are and that although some women decline there is actually a very high uptake. The nicotine element is the addictive side of it, but it does not cause any side effects to the fetus.

Jane Garvey, on behalf of Zena Young asked how the Trust decides who to offer this service to and who isn't offered the testing?

Lindsey Reid explained that everyone is offered CO testing.

Zena Young enquired whether there was sufficient capacity to meet the potential demand for CO testing.

Lindsey Reid confirmed this and clarified that it is all part of the routine antenatal

check.

The Co-Chair, Jane Garvey asked if there was anything the Trust can do if a woman's partner smokes.

Lindsey Reid confirmed that at the moment, they can ask them whether they want help but at present are not able to provide them with the service. In the future, they will be able to provide family support as well.

Richard Kennedy explained that the resumption of the CO testing is a concern across the country because of Covid19 but it has been approved by PHE. He went on to stress that smoking is the single most important factor to consider in the prevention of stillbirths. He also asked what sort of funding SaTH had received specifically for Maternity.

Guy Calcott confirmed that there was funding allocated to SaTH for this purpose. In further discussion regarding funding Louise Barnett confirmed that the local authority is funding the Trust's in-house public service for the first year which will concentrate on smoking and also other health issues.

Hayley Flavell explained that she felt it important that there should be an integrated approach that covers the whole public agenda and includes the maternity work. She proposed to hold discussions with colleagues to explore the matter in more detail.

In response to a question from Jane Garvey about the high incidence of smoking in some areas of the Trust's catchment, Ms Reid confirmed that the Trust still needed to make progress to achieve the national average of 10% with the current percentage of the local pregnant population being 11.8% in Shropshire and 15.2% in Telford & Wrekin.

In discussion, Richard Kennedy stressed the importance of personal contact to support these women in their quitting and the sustaining of their quitting.

Lindsey Reid responded that the new service will have a much bigger team which will be able to support this.

Louise Macleod confirmed that, based on her experience, it is a very difficult subject both to raise it and also to help them to stop and make sure they have the right support.

Lindsey Reid explained that most women underestimate how difficult it is to stop and feel that because they are pregnant, they will just be able to quit immediately. It can be a very difficult process for some as pregnant women metabolise their nicotine differently.

In response to a question from Jane Garvey regarding whether damage to the fetus by smoking is worse in the early stages of pregnancy, Lindsey Reid confirmed that the effect occurs throughout pregnancy but when the placenta starts working is when it is at its worse.

<u>Element 2: Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR)</u>

Lindsey Reid explained there is strong evidence to suggest that FGR is the biggest risk factor for stillbirth. Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it

gives the option to consider timely delivery of the baby at risk.

This element has 16 standards and is divided into:
• Prevention – assessing need for aspirin and smoking status and referral
• Risk assessment – factors for FGR at booking for maternity care
• Surveillance – Serial growth scans for women assessed as having an increased risk of FGR
• Management – care pathway of women with suspected fetal growth problems
• Multiple pregnancy – risk assessment and management of fetal growth

Lindsey Reid presented the current position:

- SBL requirement for serial growth scans has been complied with since 2018
- Clinical Referral Team and risk assessment processes updated since 2020
- Staff undertaking low risk screening (Symphysis Fundal Height measurements using a tape measure) are trained and have undertaken a competency assessment

Lindsey Reid explained that many Trusts struggled with this implementation of serial scanning due to capacity issues; SaTH have addressed this by implementing the following:

- Expansion of midwife sonography team
- Guideline reviews
- Multiple pregnancy clinic
- SaTH antenatal detection of FGR is 60% (national average is 58%).
- Measure of the effective detection and management of FGR and Small for Gestational Age (SGA).
  - Percentage of babies 37+6 weeks in SaTH is 47% (national average 52%).
  - Percentage of babies 3rd centil

Lindsey Reid welcomed any questions on this element.

In response to a question from Jane Garvey, Lindsey Reid explained her journey as a midwife and midwife sonographer emphasising the importance of the screening tool.

Richard Kennedy asked whether the service is using a uterine artery doppler at 20 weeks for women at high risk of fetal growth restriction. He explained that the Saving Babies Lives care bundle advice and guidance is that uterine artery dopplers should be undertaken routinely at 20 weeks in women who are at high risk of fetal growth restriction. The purpose is to detect high risk patients because if the doppler reading is normal at that stage, indicating that the blood flow through the uterus is normal at that stage, then subsequent scanning can be delayed until 32 weeks in line with the Royal College of Obstetricians & Gynaecologists protocol.

In response, Lindsey Reid that the test was not undertaken because women are routinely scanned from 26 to 28 weeks and when the Saving Babies Lives 2 care bundle introduced the requirement for uterine artery testing we continued with the existing scanning arrangement.

In discussion, Richard Kennedy confirmed that although SATH was not taking the

recommended approach its alternative approach is safe. He explained that other units are also struggling to implement this recommendation because of the skills required to do the test routinely at 20 weeks for women at risk of fetal growth restriction. He confirmed that the direction of travel should be to develop the capacity to undertake this test.

In response, Martyn Underwood provided an update on the plans to introduce the test, explaining that he had had early discussions with the fetal medicine consultant at Birmingham Women's Hospital who was going to introduce this at SATH with the sonographers. He confirmed that a business case had been submitted and was awaiting confirmation of funding.

Element 3: Raising awareness of reduced fetal movement (RFM)

Lindsey Reid explained that enquiries into stillbirth have consistently described a relationship between episodes of RFM and stillbirth, ranging from the 8th CESDI report published in 2001 to the MBRRACE-UK reports into antepartum and intrapartum stillbirths, respectively. In all of these case reviews unrecognised or poorly managed episodes of RFM have been highlighted as contributory factors to avoidable stillbirths. In addition, a growing number of studies have confirmed a correlation between episodes of RFM and stillbirth. This relationship increases in strength when women have multiple episodes of RFM in late pregnancy (after 28 weeks' gestation).

Lindsey Reid went on to explain that this element has 5 standards, covering the provision of suitable information to mothers, appropriate induction of labour, and continuous learning within the Trust including comparison with peers' outcomes.

Lindsey Reid presented the current position:

- Provision of Reduced Fetal Movement (RFM) leaflet and discussion before 28 weeks gestation.
- Survey of women about RFM, service provision and barriers
- Recent audit of notes (April 2021) demonstrated a documented 91% compliance of leaflet provision and a 95% documented compliance of RFM discussed before 28 weeks.
- This demonstrates a significant increase in leaflet provision since June 2020's audit of a 70% documented compliance.
- Our guideline for RFM has been updated and reviewed externally
- Dedicated Registrar / Tier 2 doctor covering triage during the day to review women with RFM

Lindsey Reid provided details of the Care Pathway Developments for this element:

- For women presenting with RFM, we have developed a robust care pathway using the Birmingham Symptom Specific Obstetric Triage System (BSOTS).
- Our version has been approved by the Midlands Clinical Network panel. They will share the pathway as "Good practice".

Lindsey Reid opened up the floor to questions on this element.

The Co-Chair, Jane Garvey asked how much women know about the importance of movement.

In response to a question from Jane Garvey regarding how much women know

about the importance of their baby's movement, Lindsey Reid explained that the main issue is identifying who a woman trusts enough to ask a question. Often, this will be their mothers and sisters who will share experiences. She added that the Tommy's leaflets that are given out are quite specific and explanatory. The key is making women more aware of what their baby is doing.

Louise Macleod added that the MVP has been heavily involved in this for some time now and they try to promote this message as much as possible. Two surveys have been done on the topic. She concurred that women usually go to their mothers or sisters for answers, so the information delivered needs to be dispensed across the generations. She also explained that women tend to wait because of the journey to the hospital or lack of childcare for other children, etc. There are several factors that affect the monitoring of this element. She feels this is something that needs to be addressed nationally.

In discussion regarding a possible reluctance of women to make contact with the service regarding reduced fetal movement, Lindsey Reid emphasised how important it is for women to contact the unit for advice. Guy Calcott confirmed that the default position is to invite to attend the unit any woman that calls about reduced fetal movement, and in these circumstances the advice would be given by a midwife or doctor.

<u>Element 4: Effective fetal monitoring during labour</u>

Lindsey Reid explained that CTG (Cardiotocograph) is a well-established method of confirming fetal wellbeing and screening for fetal hypoxia (low oxygen in the fetal tissues). In the case of a high-risk labour where continuous monitoring is needed, CTG is the best clinical tool available to carry this out. However, CTG interpretation is a high-level skill and is susceptible to variation in judgement between clinicians and by the same clinician over time. These variations can lead to inappropriate care planning and subsequently impact on perinatal outcomes.

This element has 7 standards.

Lindsey Reid presented the current position:

- Lead Consultant in place
- Lead Fetal Monitoring Midwives in place
- Guidelines updated to include risk assessment at the onset of labour, hourly reviews of fetal wellbeing in both high and low risk labours, hourly fresh eyes for labours with continuous fetal monitoring
- Continuous fetal monitoring guideline approved by the Midlands clinical network panel
- Funding approved for expansion of consultant time to deliver Fetal Monitoring training

Lindsey Reid went on to explain the current situation and future plans for the staff fetal monitoring training:

<u>Current:</u>

- K2, online package that provides training and competency assessment (this meets the current SBL Care Bundle v2 minimal requirement)
- Additional fetal monitoring lecture
- Twice weekly lunchtime fetal monitoring case reviews

Planned:

- Full day multidisciplinary mandatory Fetal wellbeing day planned for this year
- Implementation of a competency training document developed by Midlands Clinical Network

Lindsey Reid welcomed any questions on this element.

The Co-Chair, Jane Garvey sought clarification regarding the phrase “variation in judgement” and the implications of this.

Mei-See Hon explained that fetal monitoring is quite complex in its interpretation which is why a second person can call upon (fresh eyes). If that second person doesn’t agree with the initial interpretation, it is important to escalate it until such point as you are assured about fetal wellbeing.

Mei See Hon added that it is important to note that there is a central monitoring system that has been in place for 3 years that projects all CT monitorings onto a screen in the office which means that all staff can monitor the CT screenings at any given time which gives another opportunity to pick things up that may look abnormal.

Anthea Wilson asked whether this amount of monitoring still reduces the mother’s movement as much as it used to and whether the training includes communication with mothers about what it all means for them.

Lindsey Reid confirmed that there is a better degree of mobility now, but it depends on the situation: the higher the risk, the more they need to be able to monitor. She also confirmed that part of the training is communication with the mother and the partner.

Mei-See Hon added that the cables used for monitoring are quite long to encourage mobility during labour. There is also the option of monitoring through a fetal scalp clip.

Element 5: Reducing preterm births

As the lead for preterm births, Guy Calcott presented the 5th element.

Guy Calcott explained that a preterm birth can have a significant impact on the child’s health. He added that prematurity is grouped into different categories depending on your stage of gestation: Extreme prematurity (22 to 27/28 weeks), Very preterm (up until 32 weeks) and Late preterm (up until 36 weeks and 6 days).

The aim is to reduce the number of preterm births and optimise care when preterm delivery cannot be prevented.

This element has 19 standards and is divided into:

- Prediction: Assessment of women at booking for the risk of preterm birth
- Prevention: Assessing need for aspirin and smoking status and referral
  Access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth
- Preparation: Optimising care of women and babies at high risk of

	imminent preterm birth • Multiple pregnancy: Risk Assessment and Management Guy Calcott went on to present the current position: Data Available for Q3/Q4 for 2020/2021: • Antenatal Steroids given within 7 days of preterm birth: 59% ➢ No National Comparator as this is a new standard ➢ Previous National standards (NNAP) used ANY steroid prior to birth • Magnesium Sulphate given prior to birth under 30 weeks gestations: 91% ➢ National Average = 82% (NNAP 2019) • Babies Born at SATH under 27 weeks: N=2 ➢ Both reviewed and no option to transfer prior to birth due to rapid delivery • Birth between 16 weeks and 23+6 weeks: 0.5% in 2020 ➢ Births between 24 weeks and 36+6 weeks: 6.5% in 2020 (internal data). ➢ National Average 7.8% in 2019 Guy Calcott explained the plans for the service expansion: • Appointment of Lead Consultant for Preterm Birth Prevention (himself) ➢ Provides continuity of clinical care and ultrasound scan support ➢ Representation of SATH at regional network meetings • Creation of weekly dedicated Preterm Birth Prevention Clinic run by consultant with Interest in Preterm Birth ➢ Antenatal Care individualised for each patient, standardised to NICE and SBLv2 ➢ 630 Appointments offered per year • Recent appointment of another new consultant with Interest in Preterm Birth Prevention to increase capacity further and better maintain continuity • Introduction of Multiple Birth Clinic Guy Calcott presented the plans for Service Improvement: • All new Preterm Birth Prevention Guideline – referral criteria aligned to SBL v2 and management aligned to NICE. • Referral pathway to tertiary hospital (Royal Stoke University Hospital) created for complex cases • Retrospective Review of all preterm cases where steroids not given within 7 days regardless of outcome. • Retrospective review of all pre-term babies where place of birth was outside guidance regardless of outcome Guy Calcott expanded on the Ongoing Developments: • Management of Preterm labour and Birth guideline being updated in collaboration with West Midlands Preterm Birth Network • Enhanced Delivery predication testing ➢ Quantitative Fibronectin ➢ QUIPP app • Work to extend preterm care to Pre-conception for women at very high risk and post-natal clinics to prepare for future pregnancies • Strengthening of in-utero Transfer Pathways in collaboration with West Midlands	

	Guy Calcott welcomed any questions on this element. Richard Kennedy enquired whether the service had enough capacity to sustain this work. Guy Calcott confirmed that at present capacity is managed by utilising the emergency theatre in the maternity ward and working extra hours, but this will be made easier with the employment of his additional colleague. Jane Garvey asked whether a woman ever refuses steroids. Guy Calcott said they do occasionally but once the benefits are explained, they usually tend to agree in the early stages of pregnancy. At later stages they may still decline. <u>Additional Transformation Plans:</u> Lindsey Reid went on to present the future plans for the service: • This year will see SaTH's maternity information system changing to Badgernet. • This system is programmed with: ➢ SBLCB related risk assessments and prompts Lindsey Reid demonstrated the outcome so far: • In 2017, a significant amount of money was allocated to CTG training • In 2018, the SBL serial growth scanning started • As a result, there is a downward trend in stillbirths which is in line with the national trend Lindsey Reid concluded that positive progress is being made to deliver the SBL Care Bundle v2 and that the data will be validated at the Maternity Transformation Assurance Committee on 13th July 2021. Jane Garvey thanked Lindsey Reid and Guy Calcott for their excellent presentations and their work in this area. Jane Garvey invited Belinda Green to explain her role and her experience of the unit. Belinda Green explained that she had spent some time in a "clinical immersion role" within the unit and confirmed that she had been impressed with the progress that had been made in implementing the SBL Care Bundle and with the midwives on the "ground floor" who were passionate about what they did and were making a difference. She went on to highlight the outstanding need to put in place a very clear leadership and governance structure for the service; an issue that Hayley Flavell explained that the organisation is familiar with and is managing. Richard Kennedy added that the challenges faced in Midwifery are not unique to SaTH and that he was impressed with the Obstetric Leadership. Catriona McMahon added that not only is Hayley Flavell very well sighted on the challenges faced by Midwifery Leadership but Trust Board as a whole.	

033/21	**Discussion and Reflection** The Co-Chair, Jane Garvey opened the discussion and invited comments about how these meetings are going and how the process is panning out. Louise Macleod noted that they appreciate being involved and look forward to presenting the result of their discussions in September. Jane Garvey thanked Louise Macleod and MVP for their involvement and commitment. Zena Young added that it was very helpful to hear the details and discussions from the clinicians. Jane Garvey concurred. Mike Wright gave an overview of the topic of discussion for the next meeting which will be around Obstetrics Anaesthesia. He also proposed that the meeting be cancelled in August with the Committee resuming in September. Jane Garvey encouraged everyone to keep sending in questions and comments about anything they would like discussed and answered. Anthea Wilson commented that in the last meeting, she suggested that social media messages get sent out to get feedback from women how are currently receiving services from SaTH. She advised the meeting that Powys CHC has now put out a survey via social media which has been live for just over a week. Nine responses have been received and they are hoping to run it for a bit longer to get more responses to be able to join in with the Maternity Voices presentation and present their findings. Jane Garvey thanked Anthea Wilson for the update and offer, confirming that it would be considered for a future meeting.	

034/21	**Closing remarks from the Co-Chairs** The Co-Chair, Jane Garvey thanked all the speakers and participants.	
035/21	**Date of next Board of Directors' meeting in private:** At 0900 on Thursday 22 July 2021 – vis MS Teams	
MEETING CLOSED		**1109**

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 July 2021

Agenda item	178/21			
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			
	For noting			
	For information			
	For consent			
Presented to:	Directly to the Board of Directors			
Dependent upon (if applicable)**:**				
Executive summary:	This report presents an update to the Trust's Ockenden Report Action Plan and other related matters. Progress continues to be made against the required actions from the first Ockenden Report (2020), and this work continues at pace. There are some challenges in meeting some of the delivery and evidence dates the Trust has set itself to achieve, but these are being managed. Staff absences have compounded some of this work but some of these now appear to be resolving. The Board of Directors is requested to receive and review: • This report, the Ockenden Report Action Plan at **Appendix One** and Draft Exception Reports at **Appendix Two** • Decide if any further information, action and/or assurance is required			
Appendices	**Appendix One:** Ockenden Report Action Plan at 30th May 2021 **Appendix Two:** Ockenden Report Action Plan Draft 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 10th June 2021. In addition, updates are provided on 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 as at 25th June 2021 is presented at **Appendix One** for the Board's consideration (Note: Glossary and Index are at the back of the plan). The latest commentary is provided in blue text.

3. STATUS OF REQUIRED ACTIONS

3.1. The **'Delivery Status'** position of each of the 52 actions as at 25th June 2021 is summarised in the following tables. The first shows the 'current' and 'proposed' position against each. To explain this further, a number of actions have been reviewed by a subset of the Maternity Transformation Assurance Committee (MTAC) to give a preliminary view ahead of the next formal MTAC meeting on 13th July 2021. From this review, it is possible that a number of actions could change their status, subject to them being ratified formally at the next MTAC meeting. In order to ensure full transparency, these are shown in the 'proposed' column to show what the possible movement could look like. However, and as has been discussed previously, these need to be caveated as they will need to go through the full and due testing and validation process first before confirming.

[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.

Delivery Status							
	Total # recommendations	Not yet delivered		Delivered, Not Yet Evidenced		Evidenced and Assured	
		Current	Proposed	Current	Proposed	Current	Proposed
LAFL	27	15	13	12	14	0	0
IEA	25	17	9	7	15	1	1
Total	52	32	22	19	29	1	1

The following table summarises the overall 'Delivery Status' direction of travel, which is positive.

Delivery Status Direction of Travel				
	Not yet delivered	Delivered, Not Yet Evidenced	**Evidenced and Assured**	Trend
LAFL	-2	+2	0	
IEA	-8	+8	0	
Overall	-10	+10	0	

3.2. Using the same approach, the **'Progress Status'** position of each action as at 25 June 2021 is summarised in the following table:

Progress Status											
	Total # recommendations	Not Started		On Track		At Risk		Off Track		**Completed**	
		Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed
LAFL	27	0	0	27	23	0	0	0	4	0	0
IEA	25	3	0	21	23	0	0	0	1	1	1
Total	52	3	0	48	48	0	0	0	0	1	1

3.2.1. The following table summarises the overall 'Progress Status' direction of travel, which shows a mixed picture, as follows:

Progress Status Direction of Travel						
	Not Started	On Track	At Risk	Off Track	**Completed**	Trend
LAFL	0	-4	0	+4	0	
IEA	-3	+2	0	+1	0	
Overall	-3	-2	0	+5	0	

3.3. The four actions that were declared in the previous two months as being 'off track' have revised their delivery dates, and these have been approved by the Maternity Transformation Assurance Committee. These are now back on-track.

3.4. Five further actions are now 'off track", having breached their expected 'delivery' and/or 'evidence required' dates. These are four LAFL's and one IEA, as follows:

3.4.1. **LAFL 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.

3.4.2. **LAFL 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.

3.4.3. **LAFL 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.

3.4.4. **LAFL 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.

3.4.5. **IEA 1**.4 - An LMS cannot function as one maternity service only.

3.5. The current position for each of these is provided in the narrative written in blue font in the Status Commentary section of the Ockenden Report Action plan at **Appendix One.** In addition, draft exception reports for each are attached at **Appendix Two,** which provide further details. These are still draft as they have yet to be discussed and finalised at the next MTAC meeting on 13th July 2021. However, they are presented to give some sense of where these actions are currently.

3.6. It is suggested that the MTAC should undertake a review of all of the delivery and evidence dates that the Trust set itself in order to ensure that they are fair and appropriate still. The Board is reminded that some of the original dates set by the Trust may have been over-ambitious initially (as these are discretionary to the Trust and are not mandated).

3.7. It is also worth advising the Board that the people leading, coordinating and working on this plan are the same people that have been providing added and extra input and focus to the Clinical Negligence Scheme (CNST) for Maternity Incentive Scheme work and thus, have been spread thinly during May and June. However, this position will improve during July 2021.

3.8. A further 15 actions are requiring to be evidenced by the 30th June 2021. These all require audit evidence to move to the 'evidence and assured' rating. This work has started, however, due to the need for a key staff member to take compassionate leave and, also, amendments that had to be made to the audit tool as a result of the minimum evidence requirements for IEA's published by NHSE/I in May, it has not been possible to complete this work during June 2021. It is most likely that these actions will breach the end of June date but it is hoped that this position can be recovered during July and August 2021.

3.9. In summary, this month presents a mixed picture. However, good progress is being made overall in relation to the number of actions moving to 'delivered but not yet evidenced' status. The reasons for more actions going 'off track' will be reviewed at MTAC. It is anticipated that, whilst there has been an unavoidable delay to undertaking a number of audits, this position will now improve.

4. OTHER MATTERS RELATING TO THE OCKENDEN REPORT ACTIONS

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

4.1.1. The Trust has uploaded all of its current evidence to the national portal within the required timeframe. The position of all NHS providers of maternity care will be

compared and contrasted, and feedback on what this is showing will be presented back to trusts in due course.

4.2. External Expert Advisory Panel (EEAP)

4.2.1. The Trust's Chair has written to the EEAP to agree the next steps in terms of progressing work with the Panel.

4.3. Workforce Plan, Including Birthrate Plus Assessment

4.3.1. The Trust has received the final Birthrate Plus report from the audit that was undertaken in the last quarter of 2020. The Interim Head of Midwifery and Interim Deputy Head of Midwifery have produced a position paper that is being considered currently, ahead of producing a final report. It is anticipated that, once the final report is ready it will be presented to the Board at its July meeting in public.

5. OCKENDEN REPORT ASSURANCE COMMITTEE (ORAC)

The fourth Ockenden Report Assurance Committee took place on Thursday 24th June 2021. The main topic for discussion was the Trust's progress against the Saving Babies' Lives Care (SBL) Bundle (version two). This is a national initiative to reduce the incidence of stillbirths in England. Mrs Lindsey Reid, Lead Midwife for SBL and Mr Guy Calcott, Consultant Obstetrician and Gynaecologist were the main presenters. This was a really positive meeting, with excellent progress being made by the Trust against all of the elements of the care bundle. 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. There are some challenges in meeting some of the delivery and evidence dates set by the Trust for itself but these are being managed. Staff absences have compounded some of this work but some of these now appear to be resolving.

7. ACTION REQUIRED OF THE BOARD OF DIRECTORS

The Board of Directors is requested to receive and review:

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

Hayley Flavell
Executive Director of Nursing
June 2021

Appendix One: Ockenden Report Action Plan at 30th June 2021
Appendix Two: Ockenden Report Action Plan – Draft Exception Reports – June 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	Guy Calcott	SaTH NHS SharePoint
4.55	All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Ongoing antenatal care pathway development under way. Videos and leaflets available plus BabyBuddy app. Access to/utilisation of these needs to be determined. Key info also provided in handheld notes. Method to be introduced to confirm mother's understanding / receipt of info. MTAC agreed on 22/04/2021 that the evidence provided, including information videos, virtual ward tours, online antenatal classes, the new Personalised Care and Support Plan (co-produced with the MVP) and Place of Birth Choice leaflet, was sufficient to move this to 'Delivered, Not Yet Evidenced'.	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
4.56	The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	This action will be proposed for marking as 'Delivered, Not Yet Evidenced' at the next MTAC, with evidence including proof that a dedicated obstetrician and two specialist midwives are now in substantive posts; all with suitable allocation of time to devote to training and knowledge update of EFM. Job descriptions and person specifications showing the expertise and experience required, and evidence of training provision and continuous professional development were also provided.		31/08/21		Hayley Flavell	Shirley Jones	

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.57	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	A dedicated SBL project midwife in post, progress against Saving Babies' Lives (SBL) v2 is monitored within scope of Maternity Transformation Plan (MTP). The planned peer review, undertaken with Sherwood Forest Hospitals NHS Foundation Trust (SFH), has been conducted, showing >90% of the evidence to demonstrate compliance has been provided and reviewed. Noting that SBL is an ongoing requirement, rather than one-off deliverable, this action will be proposed at next MTAC to be marked as 'Delivered, Not Yet Evidenced' based on the assurance so far carried out. It was the subject of a deep-dive review at the June ORAC meeting.		15/07/21		Hayley Flavell	Shirley Jones	
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	Shirley Jones	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	A review of the governance team structure underway, and the Trust has begun recruitment of a dedicated Head of Clinical Governance, initially for a six-month period. The Trust has also set up two new divisional governance forums, NOIR and DOG, with the aim of ensuring timely and thorough conduct of investigations. Despite this, the MTP Group do not feel there is enough evidence in place to recommend MTAC to mark this deliverable as 'Delivered, Not Yet Evidenced', hence it should be marked as 'Off Track', and an Exception Report will be provided to MTAC and the Trust Board shortly.		30/09/21		Hayley Flavell	Shirley Jones	
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	A review of Governance team structure is underway, actively supported by our SFHNHST partners with a formal Terms of Reference in place. The Trust has taken steps to introduce additional resources (incoming Head of Clinical Governance) and new forums have been set up that will help deliver this action (specifically the Divisional Oversight Group and NOIR). However, the sub-tasks required to deliver it, including the conduct of an assurance exercise and cross-referencing between Datix and MEDWAY has not yet been carried out, hence MTPG will not advise MTAC to mark this as 'Delivered, Not Evidenced'. Therefore the action should be marked as 'Off Track', and an Exception Report will be filed and shared with MTAC and the Trust Board.		30/09/21		Hayley Flavell	Shirley Jones	

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.61	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	Shirley Jones	SaTH NHS SharePoint
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	Guy Calcott	SaTH NHS SharePoint
4.63	Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Currently achieved. Need to be able to provide on-going evidence, Retrospective audit of notes and ongoing audit to be conducted. MTAC agreed on 22/04/2021 that the evidence provided (completed obstetric handover sheets) was sufficient to move this to 'Delivered, Not Yet Evidenced', but noted that they would need to see the new handover sheet that is being introduced to add greater control and oversight, and the results of a formal audit, before it can be accepted as 'evidenced and assured'.	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
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	Shirley Jones	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	31/07/21	Not Yet Delivered	On Track	Two bereavement midwives in place. Business case submitted for additional 90 hrs of consultant time for delivery of bereavement care. Need to appointment obstetrician to co-lead on bereavement care. 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, and May MTAC agreed delivery date rebaseline from 31/03/21 to 31/07/21; evidence rebaseline from 30/06/2021 to 30/09/2021.		30/09/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
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, specifically formal allocation of Consultant time in addition to the two specialist Bereavement Care midwives already in post. The Trust has 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 has been postponed due to the Coronavirus pandemic, but will be rescheduled. Based on the fact that despite no formal PA allocation, consultant input to Bereavement Care is in place, and well-evidenced care and compliance with HSIB and Early Notification, including family involvement by the midwives, MTPG will recommend next MTAC meeting to mark this as 'Delivered, Not Yet Evidenced'.		31/08/21		Hayley Flavell	Shirley Jones	

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Escalation policy already in place. Updated November 2020 to describe situations where Consultants must be in attendance. Process in place to assess competencies of all middle grade doctors, not just O&G trainees. Compliance with escalation process to be audited. At their meeting on 22/04/2021, MTAC approved status to be 'delivered, not yet evidenced' based on the escalation process poster that is displayed on the wards. The next wish to see the completed guidelines / SOP document, and an audit of adherence.	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
4.73	Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	The risk assessment process at booking has been redesigned with early referral for women with pre-existing medical conditions - they 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 / tertiary Physician. The development of specialist Maternal Medicine Centres is a National priority, 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. The Service employees a Clinical Referral Team and a Risk Assessment and procedure for the allocation of an appropriate local consultant. Additionally, it is setting the conditions to nominate a Maternal Medicine Centre lead consultant once the Midlands Centre is established. Full engagement with the preparations for this by SaTH with Midlands Perinatal has been evidenced. However, the Trust acknowledges that some of its referral guidelines require an update. Further, the specific criteria for referral to the Maternal Medicine Centres is something the Centres themselves would have to lead on, hence somewhat out of our control at this time. To that end, MTPG advise MTAC to leave this action as 'Not Yet Delivered', and as the target date has been missed, mark it 'Off Track'. An exception report, comprising mitigation plan will be supplied to MTAC and the Trust Board shortly.		30/06/21		Hayley Flavell	Guy Calcott	

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.74	There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Complex antenatal and postnatal inpatients are identified at the morning and evening Delivery Suite handovers 7 days a week. This information is recorded on the handover sheets. The on call consultant attends the antenatal ward round daily to conduct a ward round along with the Tier 2 doctor. They also attend the postnatal ward to review any women identified as complex. This will be evidenced by an attendance audit and through auditing the information on the handover sheets. Further clarity to be sought of specifics of this requirement i.e.: what constitutes demonstrated expertise? MTAC approved this as 'Delivered, Not Yet Evidenced' at their meeting of 22/04/2021, noting the revised risk assessment form and CRT referral process (as with LAFL 4.54 and 4.61).	22/04/21	30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20	TBC	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	Shirley Jones	
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	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	Shirley Jones	
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	TBC	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	Shirley Jones	
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	Shirley Jones	

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.90	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	TBC	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	Shirley Jones	
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	Will Parry-Smith	SaTH NHS SharePoint

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 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	Shirley Jones	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	31/07/21	Not Yet Delivered	On Track	Policy for escalation already in place with audits taking place every three months by a senior Neonatologist. Adherence to exception reporting and escalation policy in line with service specification and Network requirements – to be monitored on monthly basis Recording and filing of discussions with NICUs outside of the exceptions to be implemented Review and revise the existing SOP for escalation by tier 2 staff/senior nurses to on call consultant 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. May MTAC approved revised delivery date from 31/03/21 to 31/07/21 and evidence date from 30/04/21 to 30/09/21		30/09/21		Hayley Flavell	Shirley Jones	

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

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4.99	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	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 plans for such placements to take place at Royal Stoke Hospital, New Cross Hospital and Birmingham Women's Hospital. Regrettably, the Women and Children's Division has not been able to advance this as the business cases for an additional (neonatal) consultant has not yet been approved. Accordingly, attachments cannot be put in place without putting the onsite rota at risk. Therefore, MTPG advise MTAC to revert the status of this action to 'Not Yet Delivered' and mark it 'Off Track'; consequently an Exception Report is required and will be supplied to MTAC and the Trust Board shortly.		30/10/21		Hayley Flavell	Janine McDonnell	SaTH NHS SharePoint

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IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight													
1.1	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Y	10/12/20	31/10/21	Not Yet Delivered	Not Started	Review at LMNS Board in order to consider what data is required and in what format Work being scoped with NHSEI to develop national maternity dashboard with SaTH as a key stakeholder				Hayley Flavell	Shirley Jones	
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	Full embedded status depends on joining with a larger LMNS to support this process. However, MTPG advise MTAC to mark this as 'Delivered, Not Yet Evidenced' based on compliance with the minimum evidence requirements published for this action by NHSEI in May, which proves that all cases which fulfil PMRT criteria are currently reviewed with external panel member present (typically an obstetrician from Walsall NHS Trust); an audit having been carried out to assure this and proof given that the presence of the external person is clearly set out in the relevant guidelines.		31/07/21		Hayley Flavell	Shirley Jones	
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. LMNS and CCG have shared copious evidence of plans to implement the Perinatal Clinical Quality Surveillance Model, plus minutes and organograms showing the formal receipt of information pertaining to maternity issue including SIs, Continuity of Carer roll-out and MVP co-production. Accordingly, MTPG feel MTAC would be justified in marking this as 'Delivered, Not Yet Evidenced', but this is a difficult judgment as the NHSEI minimum evidence requirements for IEAs, published in May 2021, do not allude to this specific action.				Hayley Flavell	Hayley Flavell	
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	30/06/21	Not Yet Delivered	Not Started	SATH currently a single trust LNMS. Issue raised with NHSI/E regional office. Review of membership of LMNS with a view to joining a larger LMNS. Review of current structure and work streams to ensure adequate effective oversight. This is still underway as of June, and no progress can be reported. The deadline having passed, this must be noted as 'Off Track' and an Exception Report is needed. MTPG will liaise with executive leadership on this and supply the report to MTAC as soon as practicable.				Hayley Flavell	Hayley Flavell	
1.5	The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.	Y	10/12/20	30/06/21	Delivered, Not Yet Evidenced	On Track	This is in place but is not yet evidenced	31/01/2021			Hayley Flavell	Hayley Flavell	

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

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
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	31/07/21	Not Yet Delivered	On Track	Review and strengthen SI reporting process to Trust Board and LMNS. Discussions commenced on how best to do this. Quarterly report to Trust Board using peer as example of reporting process to be developed 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. The May MTAC accepted the exception report and agreed revised delivery date from 30/04/21 to 31/07/21 and evidence date from 30/06/21 to 30/09/21.		30/09/21		Hayley Flavell	Shirley Jones	

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Immediate and Essential Action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	These roles are being developed, defined and recruited to nationally. It is understood that this process in underway. The NHSEI minimum evidence requirements for IEAs, published in May 2021, made clear that as no progress has ben announced on the national initiative, Trusts are not expected to demonstrate any evidence of progress on this action. MTPG therefore advise MTAC to re-baseline the delivery date until October or November at the earliest. This not being within SaTH's control, there is no requirement or benefit in marking the action as 'Off Track'.				Hayley Flavell	Hayley Flavell	
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Once in post, methodology for this is to be developed. The NHSEI minimum evidence requirements for IEAs, published in May 2021, made clear that as no progress has ben announced on the national initiative, Trusts are not expected to demonstrate any evidence of progress on this action. MTPG therefore advise MTAC to re-baseline the delivery date until October or November at the earliest. This not being within SaTH's control, there is no requirement or benefit in marking the action as 'Off Track'.				Hayley Flavell	Hayley Flavell	
2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Non-Executive Safety Champion in post with oversight of Maternity Services Executive Safety Champion in post – Trust Executive Medical Director (Interim co-Medical Director currently representing). Approved to 'Delivered, Not Yet Evidenced' by MTAC on 22-May-21 and ORAC on 27-May-21 and to 'Evidenced and Assured' by MTAC on 8-Jun-21 based on CNST Safety Action 9 evidence and full compliance with the minimum evidence requirements set out in the NHSEI guidance for this criterion as published on 5 May 2021. In response to MTAC direction that the Trust must engage more with MVP partners, the MTP has co-produced with MVP the 'User Experience' input and feedback system which governs the project management delivery for Workstream 5 (Comms and Engagement). As of June, we have received more than 50 such items of feedback, and are actively planning and working to deliver them. The NED has stated his intent to work more closely with MVP going forward.		30/04/21		Hayley Flavell	Shirley Jones	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	Action to be discussed with CQC at relationship meeting. SaTH enjoys an extremely positive and productive relationship with our much-valued MVP partners, who offer support, challenge and co-production. Highlights include the recently introduced 'UX' ('User Experience) card system to gather direct, actionable user feedback, and which has met with significant praise in local media and from the British Intrapartum Care Society. Notwithstanding this, the action is that CQC inspections must test this, and this aspect it outside our control. The action must therefore remain 'Not Yet Delivered'; MTPG propose a rebaselined delivery date of Oct/Nov, but there is no reason or benefit in marking 'Off Track' as the action is not within our control and there is no escalation route.				Hayley Flavell	Shirley Jones	

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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	MDT Practical Obstetric Multi-Professional Training (PROMPT) training in place and occurring monthly (doctors and midwives) Weekly MDT simulation exercises take place on delivery suite with ad hoc sessions on Midwifery Led Unit Twice weekly Cardiotocograph (CTG) learning and feedback sessions on Delivery Suite – MDT delivered by CTG midwife and/or consultant 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. MTPG advise MTAC to mark this as 'Delivered, Not Yet Evidenced' based on the (peer-reviewed) evidence supplied for Safety Action 8 of CNST and the minimum evidence requirements for IEAs published by NHSEI in May 2021, which comprises PROMPT attendance records and training content. MTP and MDT funding bid largely approved; this includes enhanced Clinical Practice Educator roles and training backfill for midwives and consultants as well as PA to deliver PROMPT and CTG training. A training budget of £190k has been approved at risk to support Workstream 4's plans, and the booking of the initial tranche (with Baby Lifeline), is underway. Further evidence of out-of-hours, in-situ MDT skills drills will be needed to get to 'green' status.				Hayley Flavell	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	Guy Calcott	SaTH NHS SharePoint

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3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	SaTH still needs identify which funding streams need to be ring-fenced including money from Health Education England (HEE) for students. However, the MTP has put forward a budget proposal for this FY totalling circa £1.9, much of which has been approved at risk, less the capital elements. The DoF has indicated her willingness to attest to a ring-fenced budget, once she has seen evidence of funding received and spent, and that external funding has been spent on training staff can attend in work time, as well as the relevant budget statements. This is in line with the minimum evidence requirements set out by NHSEI in May 2021. All of the above have been collated but not yet tested; nonetheless the MTPG feel comfortable to advise MTAC that this action can be marked as 'Delivered, Not Yet Evidenced'.				Hayley Flavell	Hayley Flavell	

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Immediate and Essential Action 4: Managing Complex Pregnancies There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.													
4.1	Women with Complex Pregnancies must have a named consultant lead.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	All women with complex pregnancies have a named consultant lead Appropriate risk assessment documented at each contact Implement a formal auditing process and report to respective local governance meetings Review of Midwifery led cases for appropriate referral onwards, to be undertaken.				Hayley Flavell	Guy Calcott	
4.2	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Antenatal risk assessments to continually reassess care pathway incorporated and being further developed, including integration with Badgernet Fetal monitoring a priority, with specific leads in place to champion awareness Individual pathways incorporating pre-existing morbidities created Connections to be developed in order to achieve holistic solution. Process already in place including specialist antenatal clinics for diabetes and endocrine, haematology, cardiac disease, rheumatology, respiratory, gastro, neurology and mental health. Review of women with additional needs at monthly multidisciplinary meetings. This may include specific medical conditions but, also, for individualised birth plans. Business case submitted for additional consultant hours to staff an "Urgent" Antenatal clinic to see women developing complex obstetric conditions. Validate and document that these requirements are being fulfilled.				Hayley Flavell	Guy Calcott	
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) Formalise connections with specialist maternal medical centres once established, and ensure clarity on referral process (which will be led by the 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. 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. Full engagement with the preparations for this by SaTH with Midlands Perinatal has been evidenced. However, the Trust acknowledges that some of its referral guidelines require an update. Further, the specific criteria for referral to the Maternal Medicine Centres is something the Centres themselves would have to lead on, hence somewhat out of our control at this time. To that end, MTPG advise MTAC to leave this action as 'Not Yet Delivered', and as the target date has been missed, mark it 'Off Track'. An exception report, comprising mitigation plan will be supplied to MTAC and the Trust Board shortly.				Hayley Flavell	Guy Calcott	

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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. Perinatal mental health guidelines and referral pathways have been shared as evidence, and this was agreed by the Trust Board in April 2021 as having been delivered				Hayley Flavell	Guy Calcott	

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Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.													
5.1	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	For Intrapartum care high risk women will have risk re-assessed hourly throughout labour with "fresh eyes" review. A separate risk assessment tool is being developed for women receiving low risk care in all birth settings to clearly document a regular review of risk status. Audit required to confirm ongoing assessment and reassessment, including during labour, is being observed Documentation contained within each woman's handheld PSCP/notes requires risk assessment to be reviewed at each contact Manual audit underway as stop-gap; weekly feedback Formalised audit to be implemented Rapid Implementation of Badgernet EPR system to allow data extraction and analysis. MTAC were satisfied to approve this to 'Delivered, Not Yet Evidenced' on 22/04/2021 based on the evidence provided for LAFL 4.54. They require to see evidence of risk assessment being made a mandatory field in Badgernet, and audit evidence to show that Place of Birth choice is reviewed at each appointment, in order to progress this to the next delivery stage.		30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
5.2	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Place of birth revalidated at each contact as part of ongoing risk assessment Mother's choices based on a shared and informed decision-making process respected This is to be checked within the scope of the audit mentioned at LEA 5.1 MTAC approved this as 'Delivered, Not Yet Evidenced' on 22/04/2021, based on evidence seen for elements of LAFL 4.54 and 4.55 (specifically, the monthly review clinic, from which minutes were provided, and the birthplace choices leaflet and online information)		30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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Immediate and Essential Action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.													
6.1	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: * Improving the practice of monitoring fetal wellbeing * Consolidating existing knowledge of monitoring fetal wellbeing * Keeping abreast of developments in the field * Raising the profile of fetal wellbeing monitoring * Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported * Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Y	10/12/20	30/06/21	Not Yet Delivered	On Track	Lead obstetrician in place with allocated time and job description – 1 SPA per week incorporating PROMPT, Fetal monitoring (0.5) & education and training. Two midwife champions have now been substantively appointed as CTG champions. This action will be proposed for marking as 'Delivered, Not Yet Evidenced' at the next MTAC, with evidence including proof that a dedicated obstetrician and two specialist midwives are now in substantive posts; all with suitable allocation of time to devote to training and knowledge update of EFM. Job descriptions and person specifications showing the expertise and experience required, and evidence of training provision and continuous professional development were also provided.		31/08/21		Hayley Flavell	Shirley Jones	
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. Audit compliance with new guideline. The two fetal monitoring midwife leads have only been in place for a matter of weeks, however have provided evidence of a multiple well-attended fetal monitoring training days throughout May and June, and plans for more to follow soon. Examples of fetal monitoring champion input to relevant SIs, as provided by the nominated consultant lead, are also available. Based on this, the MTPG advise MTAC to mark this action as 'Delivered, Not Yet Evidenced'.				Hayley Flavell	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 As with LAFL 4.57, the planned peer review, undertaken with Sherwood Forest Hospitals NHS Foundation Trust (SFH), has been conducted, showing >90% of the evidence to demonstrate compliance has been provided and reviewed. Noting that SBL is an ongoing requirement, rather than one-off deliverable, this action will be proposed at next MTAC to be marked as 'Delivered, Not Yet Evidenced' based on the assurance so far carried out. It was the subject of a deep-dive review at the June ORAC meeting. Evidence to support this is compliant with the NHSEI minimum evidence requirements for IEAs as published in May 2021, as well as those of CNST Safety Action 6.		15/07/21		Hayley Flavell	Shirley Jones	

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

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.													
7.1	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Patient information leaflets available on the Internet (SaTH Homepage), including recently developed leaflet of choice for place of birth co-produced with the MVP. Also includes link to national PIL on Caesarean section (Tommy's) and Birth after previous caesarean section (RCOG). Work on-going as part Antenatal Care Pathway sub-project; videos, leaflet and Baby Buddy app available. Developing links for women to watch videos on relevant pregnancy topics such as IOL to assist in digesting information. Women requesting a caesarean section are referred to a consultant-led birth options clinic, where this is explored and management is individualised according to their choice. Patient feedback notice boards in place on inpatient areas (translation service available). Through audit, need to confirm that the mother and partner / family have received and consumed the information as intended. Digitalisation of patient record through the implementation of the Badgernet system. The Communication and Engagement workstream includes MVP and patient representation. Review of other websites required to identify best practice. Link with local LMNS and units that also provide care to women from Shropshire to ensure consistent approach to information. MTAC approved this to 'Delivered, Not Yet Evidenced' status based on the evidence referenced for LAFL 4.55, including online and handheld information. They noted the introduction of new 'business cards' handed to mothers; the cards contain a QR link to BabyBuddy app and other verified information sources. MTAC also noted that, following a study of other Trusts' online information, including on social media platforms, and in partnership with the MVP, the Trust is moving forward with a quote to revamp their online presence to maximise accessibility, the funds coming from the MTP budget.		30/06/21		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
7.2	Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.	Y	10/12/20	31/07/21	Not Yet Delivered	On Track	Work currently on-going as part of Antenatal Care Pathway sub-project Confirm that the mother and partner / family have received and consumed the information as intended A process for auditing this will need to be established. 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. The May MTAC accepted the exception report and agreed revised delivery date from 30/04/21 to 31/07/21 and evidence date from 30/06/21 to 30/09/21.		30/09/21		Hayley Flavell	Guy Calcott	
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	Guy Calcott	

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

The Shrewsbury and Telford Hospital NHS Trust

Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

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

Accountable Executive and Owner Index

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

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	4.59	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	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.				
Action Lead:	Shirley Jones						

Reason for exception and consequences	**Mitigation**
A review of the governance team structure underway, and the Trust has begun recruitment of a dedicated Head of Clinical Governance, initially for a six-month period. The Trust has also set up two new divisional governance forums, NOIR and DOG, with the aim of ensuring timely and thorough conduct of investigations. Despite this, the MTP Group do not feel there is enough evidence in place to recommend MTAC to mark this deliverable as 'Delivered, Not Yet Evidenced', because the partnered Governance Review has not yet been completed.	1) Complete the governance review in partnership with Sherwood Forest Hospitals. 2) Allow time for the new Head of Clinical Governance to settle into their role 3) Conduct an audit of recent investigations to ensure that all took place within the mandatory timelines.
Recommendation	**What lessons have been learnt from this exception?**
The sub-plan for this particular action centred on the review. As this has not yet been completed, the only recommended course of action is to re-baseline the delivery date and continue with the plan. By way of assurance, the partnered review is now fully underway under an agreed, formal Terms of Reference between the two Trusts.	The self-imposed June deadline for this deliverable was selected in a desire to act upon the Ockenden recommendations in as timely a way as possible. It has transpired that not enough time was allowed for full implementation. The Trust acknowledged that there were not enough resources and have taken active steps, i.e. hiring the dedicated Governance Head.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:**	**To be decided at MTAC**

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	4.60	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	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.				
Action Lead:	Shirley Jones						

Reason for exception and consequences	**Mitigation**
A review of Governance team structure is underway, actively supported by our SFHNHST partners with a formal Terms of Reference in place. The Trust has taken steps to introduce additional resources (incoming Head of Clinical Governance) and new forums have been set up that will help deliver this action (specifically the Divisional Oversight Group and NOIR). However, the sub-tasks required to deliver it, including the conduct of an assurance exercise and cross-referencing between Datix and MEDWAY has not yet been carried out, so MTPG cannot yet advise MTAC to approved this action as having been delivered.	1) The risk meeting structure has been revised, but more time is needed to test as to whether the new set-up is delivering to the standard required. It does comprise multi-disciplinary representation. 2) The Divisional Oversight Group is now established, but the Terms of Reference are to be ratified. 3) The sub-task of conducting an assurance exercise, and cross-referencing between the Datix and Medway systems must be completed.
Recommendation	**What lessons have been learnt from this exception?**
The plan devised to answer this requirement remains valid, however due in part to staff absences, has not yet been fully implemented. The Maternity Transformation Programme Group advise continuing with the agreed action plan, but re-baselining the date.	The self-imposed June deadline for this deliverable was selected in a desire to act upon the Ockenden recommendations in as timely a way as possible. It has transpired that not enough time was allowed for full implementation. The Trust acknowledged that there were not enough resources and have taken active steps, i.e. hiring the dedicated Governance Head.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:**	**To be decided at MTAC**

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	LAFL 4.73	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	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.				
Action Lead:	Guy Calcott						

Reason for exception and consequences	**Mitigation**
The Service employees a Clinical Referral Team and a Risk Assessment and procedure for the allocation of an appropriate local consultant. Additionally, it is setting the conditions to nominate a Maternal Medicine Centre lead consultant once the Midlands Centre is established. Full engagement with the preparations for this by SaTH with Midlands Perinatal has been evidenced. However, the Trust acknowledges that some of its referral guidelines require an update. Further, the specific criteria for referral to the Maternal Medicine Centres is something the Centres themselves would have to lead on, hence somewhat out of our control at this time. In summary, the reason for the exception is due to a lack of clarity on specialist centres referral guidance, and lack of capacity at SaTH to update the relevant guidelines within the timeline at which delivery was initially aimed.	1) The risk assessment process at booking has been redesigned with early referral for women with pre-existing medical conditions - they 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 / tertiary Physician. 2) The development of specialist Maternal Medicine Centres is a National priority, 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. 3) SaTH is moving ahead with the appointment of a consultant to lead on liaison with the Centre(s) and the necessary guidelines update.
Recommendation	**What lessons have been learnt from this exception?**
The MTPG recommend a date re-baselined sufficiently far into the future to allow for the completion of the establishment of the Maternal Medicine Specialist Centre(s) for the Midlands and the associated referral pathway. In the interim, appointment of the liaison lead and update of associated guidelines is progressing, and SaTH is in constant liaison with the Midlands Perinatal Network; the MTPG are assured that the establishment of the Centres is proceeding positively.	This deliverable is one of a number of Ockenden Report requirements that depend in part or in full upon external deliverables (in this case the establishment of the Specialist Centres). Although the self-imposed June deadline was selected in a genuine effort for timely delivery, the MTPG accept they should not have set deadlines where so much uncertainty over ability to deliver within that timeframe existing – for expectation management, it would have been better to have left the deadline blank.
Recommendation approval (name / date)	**Original due date:** 30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:** **To be decided at MTAC**

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	LAFL 4.100	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	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.				
Action Lead:	Janine McDonnell						

Reason for exception and consequences	**Mitigation**
MTAC approved this as 'Delivered, Not Yet Evidenced' on 22/04/2021, based on evidence seen of firm plans for such placements to take place at Royal Stoke Hospital, New Cross Hospital and Birmingham Women's Hospital. Regrettably, the Women and Children's Division has not been able to advance this as the business cases for an additional (neonatal) consultant has not yet been approved. Accordingly, attachments cannot be put in place without putting the onsite rota at risk, currently. Therefore, it is suggested that MTAC reverts the status of this action to 'Not Yet Delivered' and mark it 'Off Track'.	1) In the absence of formal attachments, consultants, ANNPs and all other neonatal staff will continue to make best efforts with continuous professional development and maintenance of contemporaneous knowledge and standards. 2) A number of courses in neonatal care have been included in the Workstream 4 training plan – these include the BLL new-born examination module, neonatal life support (NLS) training etc. The budget for this has been approved and booking of the courses is underway. 3) Notwithstanding this, there is no alternative to meeting the requirements of Ockenden action 4.100 (and indeed 4.99) fully without the recruitment of the consultant as described.

Recommendation	**What lessons have been learnt from this exception?**
It is strongly recommended that the Trust explore alternative funding streams, and if this is not possible, work with divisional leadership and central finance to find other staffing costs that can be economised against, in order to free up funds to recruit to this vital post.	Financial and budgeting considerations are at the core to long-term, sustainable implementation of many of the Ockenden actions. As a programme, division and indeed a Trust, we may not have communicated and shared the ramifications of not investing in some proposals effectively enough. This is being partly resolved through the formation of the MTP working group and closer liaison with our colleagues in central finance.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:**	**To be decided at MTAC**

Ockenden Requirements Implementation: Exception Report *(DRAFT – to be presented to / approved by MTAC, July meeting)*

Date of Report:	28 June 2021	**Ockenden ID:**	IEA 1.4	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	An LMS cannot function as one maternity service only.				
Action Lead:	Hayley Flavell						

Reason for exception and consequences	**Mitigation**
Although work is underway to set up a formal partnership with another Trust, this is not yet in place, and must therefore be marked as 'Off Track' as the target date has passed.	1) To mitigate against any shortfalls that may result from being a single-service LMNS, SaTH is benefitting from its strategic partnership with Sherwood Forest Hospitals NHS Trust 2) Work to formalise a regional partnership is ongoing
Recommendation	**What lessons have been learnt from this exception?**
This is a major strategic decision for SaTH and is also dependent on a significant number of external deliverables and partners. Therefore, MTPG recommend the delivery date be rebaselined to much later in the year.	The target date initially selected for this deliverable was intended to ensure timely compliance with the recommendation. However, given the complexities and strategic importance of the decision, the time allowed was to short.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
[To be presented to the MTAC meeting in July with request to approve the mitigation plan]	**Proposed revised delivery date:**	

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).