The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
5 August 2021

Agenda item	222/21			
Report	The Ockenden Report – Progress Report			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1 BAF 2 BAF 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		CRR 16 CRR 18 CRR 19 CRR 23 CRR 27 CRR 31	
	For noting			
	For information			
	For consent			
Presented to:				
Dependent upon (if applicable)**:**				
Executive summary:	This report presents an update to the Trust's Ockenden Report Action Plan and other related matters. Good progress continues to be made against the required actions from the first Ockenden Report (2020), and this work continues at pace. Nine further actions have improved their delivery status, six actions are 'off track' currently and one is potentially 'at risk'. 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** • Take assurance from the report			
Appendices	**Appendix One:** Ockenden Report Action Plan at 13th July 2021 **Appendix Two:** Ockenden Report Action Plan Draft Exception Reports			
				

1. PURPOSE OF THIS REPORT

This report presents an update on all 52 actions in the Trust's Ockenden Report[1] Action Plan since the last meeting of the Board of Directors in Public on 8th July 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's 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 13th July 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 13th July 2021 is summarised in the following table:

Delivery Status							
	Total # recommendations	Not yet delivered		Delivered, Not Yet Evidenced		Evidenced and Assured	
		Current	Movement in month	Current	Movement in month	Current	Movement in month
LAFL	27	14	-1	13	+1	0	0
IEA	25	9	-8	15	+8	1	0
Total	52	23	-9	19	+9	1	0

As can be seen, there has been positive movement in month, with a further LAFL, and eight IEA's moving into the 'Delivered, Not Yet Evidenced Stage. This is a testament to the ongoing hard work that is underway within the Women and Children's Division and represents really positive improvement.

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

3.2. Using the same approach, the **'Progress Status'** position of each action as at 13th July 2021, is summarised in the following table:

Progress Status											
	Total # recs.	Not Started		On Track		At Risk		Off Track		Completed	
		Current	movement in month	Current	movement in month	Current	movement in month	Current	movement in month	Current	movement in month
LAFL	27	0	0	21	-6	1	+1	5	+1	0	0
IEA	25	2	-1	21	0	0	0	1	+1	1	0
Total	52	2	-1	42	-6	1	+1	6	+1	1	0

3.3. Last month, it was reported to the Board of Directors that four LAFL's and one IEA were likely to be going off track. These were confirmed by the Maternity Transformation Assurance Committee (MTAC) that was held on 13th July 2021. Since then, a further LAFL action has moved to off-track and an additional LAFL is 'at risk' of not meeting its delivery date. The exception reports that provide further details on each of these actions are provided at **Appendix Two.**

These are summarised, as follows (the first five were reported last month provisionally, but have now been confirmed):

3.3.1. **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. *This governance review has not yet been completed.*

3.3.2. **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. *This action is linked to 4.59 above.*

3.3.3. **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. *This is a complex action, some of which is taking longer than anticipated to address and, also, is awaiting national action regarding specialist maternal medicine centres, which is out of the Trust's control.*

3.3.4. **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. *This action is dependent upon the recruitment of an additional NICU consultant so that staff can be released from the unit. Funding is now in place but the recruitment has not taken place yet; hence this is now off track against its original target date. The delivery date will be revised.*

3.3.5. **IEA 1.4** - An LMS cannot function as one maternity service only. *Work is underway to set up a formal partnership with another LMNS and discussions are still taking place on the future arrangements.*

The new 'off track' LAFL this month is:

3.3.6. **LAFL 4.66** - The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway. *The reason for this not yet being implemented fully is that that the Trust is awaiting an on-site review of the pathway by the Stillbirth and Neonatal Death Society (SANDS), which has been delayed due*

to the Coronavirus pandemic. This assessment visit is scheduled to take place in November 2021. Additionally, a bid has been placed to secure the additional funding required to appoint a consultant lead (to work in partnership with the Specialist Bereavement midwives). This has not yet been approved/finalised.

There is one LAFL 'at risk' currently, which is:

3.3.7. **LAFL 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. *The business case for additional clinicians has been approved but this action has not been able to make the delivery date that was planned originally. Therefore, it is possible that this may not meet its original date of 31/10/21 but recruitment is now under way. As such, it has been declared to be 'at risk'. This action is linked closely to LAFL 4.100. The draft exception report for this is included at Appendix Two but has yet to be approved by the action owner, and be approved at MATC.*

3.4. At its meeting in public last month, the Board of Directors' was advised that the Maternity Transformation Assurance Committee (MTAC) will be undertaking 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). This work has not yet taken place at MTAC but will do so at its next meeting on 10th August 2021.

3.5. The Board will recall, also, that a number of actions were requiring audits to be undertaken before they can move to the 'evidenced and assured' status, but that these had been delayed due to unavoidable staff absence. These audits have now been undertaken but the results have not yet been through the maternity governance and assurance processes. The outcomes and outputs from these audits will be discussed at MTAC on 10th August 2021 and reported on in due course.

3.6. In summary, this month presents a mixed picture. Good overall progress is being made in relation to the number of actions moving to 'delivered but not yet evidenced' status. There are some sticking points in relation to those that are off track; however, all of these still have work being undertaken to address them.

4. OTHER MATTERS RELATING TO THE OCKENDEN REPORT ACTIONS

4.1. The Board of Directors is aware that the Trust has written to Donna Ockenden to seek clarity in relation to LAFL's 4.98 and 4.99. These relate to the provision of neonatal intensive care services (NICU) and when the Trust, as a Level 2 NICU, should consult with/seek advice from a Level 3 NICU.

4.2. The Trust is compliant fully with all current network and national guidance in this respect, and this all works well. However, these actions from the first Ockenden report put additional steps in pace, which the Trust feels are not necessary. Mrs Ockenden has been very helpful in trying to seek a resolution to this and the Trust has been advised to contact the NHSE/I Regional Office to seek clarity on these two actions. This is in progress and an update will be provided in due course.

5. OCKENDEN REPORT ASSURANCE COMMITTEE (ORAC)

The fifth Ockenden Report Assurance Committee took place on Thursday 22nd July 2021. The main topic for discussion was the Trust's progress against the actions relating to Obstetric Anaesthesia. Dr Lorien Branfield, Lead Consultant Anaesthetist for Obstetrics, was the main presenter and the session was received really positively, especially by external stakeholder members of the committee. The Chair will describe more about this committee in her report

at today's meeting. There is no meeting in August during the summer holiday period and the next ORAC will take place on Thursday 23rd September 2021.

6. SUMMARY

Good 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; however, work continues to address all of the required actions.

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

August 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	Delivered, Not Yet Evidenced	On Track	This action was accepted as 'Delivered, Not Yet Evidenced' at the July 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	Delivered, Not Yet Evidenced	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).		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	~~30/06/2021~~ New date to be agreed	Not Yet Delivered	Off Track (see exception report)	A review of the governance team structure underway. 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 and whilst improvements are being made, the MTP Group does not feel that 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.		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	~~30/06/2021~~ New date to be agreed	Not Yet Delivered	Off Track (see exception report)	A review of the 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 corporate 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.		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.

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

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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
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

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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
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	~~30/06/2021~~ New date to be agreed	Not Yet Delivered	Off Track (see exception report)	The reason this has not yet been implemented is partly due to the Coronavirus pandemic making a face-to-face visit from SANDS impossible up to this point; this makes baselining our current compliance difficult. This is due to take place in November 2021. Additionally, a bid has been placed to secure the additional funding required to appoint a consultant lead (to work in partnership with the Specialist Bereavement midwives). This has not yet been approved/finalised.		31/08/21		Hayley Flavell	Shirley Jones	

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Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Escalation policy already in place. Updated November 2020 to describe situations where Consultants must be in attendance. Process in place to assess competencies of all middle grade doctors, not just O&G trainees. Compliance with escalation process to be audited. At their meeting on 22/04/2021, MTAC approved status to be 'delivered, not yet evidenced' based on the escalation process poster that is displayed on the wards. The next wish to see the completed guidelines / SOP document, and an audit of adherence.	22/04/21	30/06/21		Hayley Flavell	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	Off Track (see exception report)	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, was accepted by MTAC and will be shared with the Trust Board shortly.		30/06/21		Hayley Flavell	Guy Calcott	

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

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

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APPENDIX ONE - OCKENDEN REPORT ACTION PLAN (as at 13th July 2021)

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.90	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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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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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
4.99	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	At Risk (see exception report)	A Business case for additional senior clinicians to offer increased clinical presence on neonatal unit - meeting the dedicated 24 hour on-site tier 2 presence - was completed and preliminarily approved early this year. The business case has now been approved Recruitment has begun – it is important that this is pursued energetically to ensure a suitable candidate is found as soon as possible. However, this took longer than anticipated to get approved; therefore, the initial delivery date of October 2021 will not be reached.	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	Not Yet Delivered	Off Track (see exception report)	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 yet as, whilst funding has now been secured for the additional neonatal consultant, recruitment has not yet taken place. Accordingly, attachments cannot commence until this person is in post without putting the onsite rota at risk, currently		30/10/21		Hayley Flavell	Janine McDonnell	SaTH NHS SharePoint

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

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 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	Delivered, Not Yet Evidenced	On Track	Full embedded status depends on joining with a larger LMNS to support this process. However, MTAC (at July meeting) approved 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	Off Track (see exception report)	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. 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. Work to formalise a regional partnership is ongoing.				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	Delivered, Not Yet Evidenced	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. MTAC (at July meeting) approved 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	Delivered, Not Yet Evidenced	On Track	SaTH still needs identify which funding streams need to be ring-fenced including money from Health Education England (HEE) for students.				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	Delivered, Not Yet Evidenced	On Track	All women with complex pregnancies have a named consultant lead. Appropriate risk assessment documented at each contact A formal auditing process has commenced and will be report to respective local governance meetings. This includes a review of Midwifery led cases for appropriate referral onwards, to be undertaken. Based on this, as well as the evidence already reviewed and accepted for LAFL 4.54, MTAC approved this as 'Delivered, Not Yet Evidenced' at their July meeting.				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	Delivered, Not Yet Evidenced	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. 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. An audit has commenced to test that correct referrals are being made at all times. Connections to the regional maternal medicine specialist centres, which are being rolled out, are being developed in order to achieve holistic solution. Based on this, and the fact the the NHSEI minimum evidene requirements were the same as for IEA 4.1 (and similar to LAFl 4.54, which has already been delivered), MTAC approved this as having been 'Delivered, Not Yet Evidenced' at their July 2021 meeting.				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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	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
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	

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 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

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 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	Delivered, Not Yet Evidenced	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 was accepted as 'Delivered, Not Yet Evidenced' at the July 2021 MTAC meeting, 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. It was noted that the requirements are closely linked to those of LAFL 4.56, which has also been accepted.		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	Delivered, Not Yet Evidenced	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, MTAC (at their July meeting) accepted this 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	Delivered, Not Yet Evidenced	On Track	Named project midwife responsible for Saving Babies Lives in place - 1.0 WTE secondment The rust has declared compliance with all required elements of the Saving Babies Lives v2 Care Bundle for the year three CNST MIS scheme. As such, this evidence needs to be presented to MTAC with a view to moving this to evidenced and assured		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

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. 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 and whilst improvements are being made, the MTP Group does not feel that 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 structure, systems and processes to settle into their role 3) Conduct an audit of recent serious incidents and externally-reportable 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 centres on the review being conducted. 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. Therefore, this was over-ambitious and is now being reconsidered.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
This was presented to the MTAC meeting in July. The exception was accepted, however a revised delivery date could not yet be reached. Therefore, MTAC advised that a full review of a number of delivery dates should be carried out.	**Proposed revised delivery date:**	**To be confirmed**

Ockenden Requirements Implementation: Exception Report

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 the 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 corporate 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.

Recommendation approval (name / date)	**Original due date:**	30/06/2021
This was presented to the MTAC meeting in July. The exception was accepted, however a revised delivery date could not yet be reached. Therefore, MTAC advised that a full review of a number of delivery dates should be carried out.	**Proposed revised delivery date:**	**To be confirmed**

Ockenden Requirements Implementation: Exception Report (Draft: this has not yet been approved by MTAC)

Date of Report:	14 July 2021	**Ockenden ID:**	4.66	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**Off Track**
Executive Lead:	Hayley Flavell	**Requirement:**	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway				
Action Lead:	Shirley Jones						

Reason for exception and consequences	**Mitigation**
The reason this has not yet been implemented is partly due to the Coronavirus pandemic making a face-to-face visit from SANDS impossible up to this point; this makes baselining our current compliance difficult. This is due to take place in November 2021. Additionally, a bid has been placed to secure the additional funding required to appoint a consultant lead (to work in partnership with the Specialist Bereavement midwives). This has not yet been approved/finalised.	1) Engage SANDS to conduct their stage 1 and stage 2 analysis of our compliance with the pathway, and book any follow-up support as required 2) Test the self-assessment that has already been conducted by the specialist bereavement care midwives in a formal setting (potentially Maternity Governance Forum) 3) Secure funding and appoint a dedicated lead Bereavement Care consultant
Recommendation	**What lessons have been learnt from this exception?**
All there steps in the above recommendation are required in order to fully implement and embed the Pathway.	The need to have a clearly articulated business case and obtain requisite funding to the consultant lead post is proving to be a recurring theme – enhanced liaison with our finance colleagues is therefore required.

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

Ockenden Requirements Implementation: Exception Report

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
This was presented to the MTAC meeting in July. The exception was accepted, however a revised delivery date could not yet be reached. Therefore, MTAC advised that a full review of a number of delivery dates should be carried out.	**Proposed revised delivery date:**	**To be confirmed**

Ockenden Requirements Implementation: Exception Report (Draft: this has not yet been approved by MTAC)

Date of Report:	28 June 2021	**Ockenden ID:**	LAFL 4.99	**Delivery Status:**	**Not Yet Delivered**	**Progress Status:**	**At Risk**
Executive Lead:	Hayley Flavell	**Requirement:**	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.				
Action Lead:	Hayley Flavell						

Reason for exception and consequences	**Mitigation**
A Business case for additional senior clinicians to offer increased clinical presence on neonatal unit - meeting the dedicated 24 hour on-site tier 2 presence - was completed and preliminarily approved early this year. However, this took longer than anticipated to get approved; therefore, the initial delivery date of October 2021 will not be reached.	1) The business case has now been approved 2) Recruitment has begun – it is important that this is pursued energetically to ensure a suitable candidate is found as soon as possible.
Recommendation	**What lessons have been learnt from this exception?**
1) Until the new consultant is in post, the rotational attachments (4.100) cannot begin.	The need for a clearly agreed business case for the MTP the is linked to Women and Children's Divisional 'Business as Usual' requirements is clear.

Recommendation approval (name / date)	**Original due date:**	31/10/2021
[To be presented to the MTAC meeting in September with request to approve the mitigation plan]	**Proposed revised delivery date:**	**To be confirmed**

Ockenden Requirements Implementation: Exception Report

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 yet as, whilst funding has now been secured for the additional neonatal consultant, recruitment has not yet taken place. Accordingly, attachments cannot commence until this person is in post without putting the onsite rota at risk, currently.	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?**
The dates for achieving this action fully should be revised in line with the anticipated recruitment timeframe for the new consultant.	Financial and budgeting considerations are at the core to long-term, sustainable implementation of many of the Ockenden actions, but some of this takes time to achieve.

Recommendation approval (name / date)		
This was presented to the MTAC meeting in July. The exception was accepted, however a revised delivery date could not yet be reached. Therefore, MTAC advised that a full review of a number of delivery dates should be carried out.	**Original due date:**	30/06/2021
	Proposed revised delivery date:	**To confirmed**

Ockenden Requirements Implementation: Exception Report

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 LMNS, 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)		
This was presented to the MTAC meeting in July. The exception was accepted, however a revised delivery date could not yet be reached. Therefore, MTAC advised that a full review of a number of delivery dates should be carried out.	**Original due date:**	30/06/2021
	Proposed revised delivery date:	**To be confirmed**