Board of Directors' Meeting
10 February 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	018/22			
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 3, BAF 4 BAF 7, 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:	Maternity Clinical Governance			
Dependent upon	N/A			
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. The Board of Directors are asked to review and take assurance from: • This report and the Ockenden Report Action Plan at **Appendix One.** • Decide if any further information, action and/or assurance is required			
Appendices	**Appendix One:** Ockenden Report Action Plan as at 11 January 2022			
				

1.0 Purpose of this report

1.1 This report presents an update on all 52 actions in the Trust's Ockenden Report[1] Action Plan since the last meeting of the Board of Directors in Public on 9th December 2021. Updates are provided on other related matters. The report must be accepted by divisional governance forums prior to submission to the Board of Directors.

2.0 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 7 January 2021.

2.2 The report sets out 52 specific actions for the Trust to implement comprising twenty-seven Local Actions for Learning (LAFL), and seven Immediate and Essential Actions (IEA's) which, in turn, comprise a further 25 related actions. In total, there are 52 actions for the Trust to implement. All the Ockenden actions (LAFL's and IEA's) have been cross-referenced to the Trust's Maternity Transformation Plan.

2.3 Since the last update to the Board of Directors, one further IEA has been accepted by the Maternity Transformation Assurance Committee as 'Evidenced and Assured':

2.3.1 **IEA 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.")** MTAC were satisfied with the evidence that had been provided by the Trust to NHSEI in May 2021, which included an approved training needs analysis, records of Multi-Disciplinary Team (MDT) training, and evidence of validation checks of this data.

2.4 Since the last report, MTAC have also accepted a further seven LAFL's as 'Delivered, Not Yet Evidenced'. These are:

2.4.1 **LAFL 4.59 "The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner**." MTAC were satisfied with evidence of:

2.4.1.1 The implementation of a revised Clinical Governance Structure for the Divisional QI Team and associated recruitment.

2.4.1.2 The recruitment of a substantive Divisional Governance Lead.

2.4.1.3 Progress towards completion of a review of the clinical governance structure, partnered with Sherwood Forest Hospitals NHS Foundation Trust.

[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.

2.4.2 **LAFL 4.60 "The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015."** MTAC were satisfied with evidence of:

2.4.2.1 The risk meeting structure having been reviewed to conduct a review of incidents.

2.4.2.2 The new patient safety model for the Trust has been implemented under the guidance of the Assistant Director of Nursing Quality Governance. A patient safety specialist is embedded as part of the Divisional Risk and QI team, which comprises midwives and nurses.

2.4.2.3 Assurance exercises related to Safety Action 10 of the Clinical Negligence Scheme for Trusts in year 3 of the scheme ("Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?")

2.4.3 **LAFL 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."** MTAC were satisfied with evidence of**:**

2.4.3.1 89% of anaesthetic consultants having completed the Practical Obstetrics Multi-Professional Training (PROMPT) by the deadline set (March 2021), and involvement of anaesthetists in PROMPT as facilitators (as well as participants).

2.4.3.2 Regular obstetric anaesthesia meetings with a learning section, and anaesthetists having designed and led multi-disciplinary emergency and live drills training.

2.4.4 **LAFL 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."** MTAC were satisfied with evidence, alongside that mentioned for action 4.85, of:

2.4.4.1 The appointment of nominated leads from the anaesthesia team for training, risk management, clinical education and quality improvement.

2.4.4.2 Minutes showing major involvement in planning a potential new service (Enhanced Maternity Care and Enhanced Recovery from Elective

Caesarean Sections) service from Dr Branfield and Dr Rizvi (anaesthetic consultants).

2.4.4.3 Close collaboration between anaesthetists, midwives and obstetricians in the design and implementation of the Ockenden Action Plan Case-Notes Review and Audit tool.

2.4.5 **LAFL 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."** MTAC were satisfied with evidence of**:**

2.4.5.1 An Excel-based tool to track dates by when updates are due.

2.4.5.2 A report detailing guidelines that have been reviewed, updated, or written from scratch since the Ockenden report came out, for obstetric anaesthesia.

2.4.5.3 The appointment of an anaesthetist to lead on continuous monitoring review and update of guidelines, with protected time to carry out this work.

2.4.6 **LAFL 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."** MTAC were satisfied that the guideline has been created and approved but recommended some further specificity on attendance guidance – this is now being worked on.

2.4.7 **LAFL 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'."** MTAC were satisfied with evidence of partial completion of audit of the Anaesthesia Clinical Services Accreditation (ACSA) standards as referenced in this action, the appointment of a quality improvement lead and the multi-disciplinary collaboration in the development and implementation of the Ockenden Action Plan Case-Notes Review and Audit tool.

3.0 Status of the required actions

3.1 The **'Delivery Status'** position of each of the 52 actions as at 11th January 2022 is summarised in the following table. 20 actions (38.5%) are now at 'evidenced and assured' status with 19 (36.5%) at 'Delivered, Not Yet Evidenced' – an overall delivery rate of 75%.

Delivery Status							
	Total # recommendations	Not yet delivered		Delivered, Not Yet Evidenced		Evidenced and Assured	
		Dec 21	Current	Dec 21	Current	Dec 21	Current
LAFL	27	12	5	5	12	10	10
IEA	25	8	8	8	7	9	10
Total	52	20	13	13	19	19	20

3.2 Using the same approach, the **'Progress Status'** position of each action as at 11th January 2022, is summarised in the following table:

Progress Status											
	Total # recs.	Not Started		On Track		At Risk		Off Track		**Completed**	
		Dec 21	Current	Dec 21	Current	Dec 21	Current	Dec 21	Current	Dec 21	Current
LAFL	27	0	0	14	16	0	0	1	1	10	10
IEA	25	2	2	16	13	0	0	4	0	9	10
Total	52	2	2	30	29	0	0	5	1	19	20

3.3 Following approved exception reports and revised deadlines as reported in the December 2021 update, one action currently remains off track:

3.3.1 **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 as some of the actions falls within the Trust to deliver, whilst other components are dependent upon national action being taken to establish specialist maternal medicine centres, which is out of the Trust's control.

The exception report for this action was provided at the October meeting, but no revised deadline has yet been agreed. The action will be reviewed again at the February 2022 MTAC meeting, at which approval for a deadline of April 2022 (for delivery) and August 2022 (for evidencing) will be sought. These timelines relate to the likely date for the Maternal

Medicine Centres to be established, and a reasonable timeframe to gather data to support an audit, respectively.

3.4 There are two Immediate and Essential Actions that are not yet delivered/not started. Again, these remain unchanged. These are:

3.4.1. **IEA 1.3 "LMS must be give greater responsibility and accountability so that they can ensure that the maternity services they represent provide safe services for all that access them"**, and;

3.4.2. **IEA 1.4 "An LMS cannot function as one maternity service only".**

These two actions are linked closely. Efforts to try and resolve them are still underway; however, a final decision on the future model and arrangements is awaited. In the meantime, the Trust and CCG are working together to improve the information flows and assurance mechanisms, albeit still within a single LNMS arrangement. The LMNS has also proposed ring-fenced time for an obstetrics consultant to manage the associated liaison with other Trusts in the region, and ear-marked funds to support this. A full update will be brought to the February 2022 MTAC, at which time it is expected that progress can be reported.

3.5. In summary, positive progress is being made in relation to the delivery of the actions from the first Ockenden Report. Many of the outstanding actions have some external dependency, are large or complex to deliver, or require significant audit and review activities to test compliance. Nonetheless, the plan remains on track for its latest agreed final delivery date of August 2022. It must be kept in mind that this is contingent to some extent upon the content of the final report.

4.0 Ockenden Report Assurance Committee (ORAC)

4.1 The seventh Ockenden Report Assurance Committee took place on 18 January 2022 with a focus on Bereavement Care and an update on progress with the Ockenden Report actions relating to Obstetric Anaesthesia.

4.2 The schedule for the next ORAC meetings has now been set, as follows:

DATE	TOPICS (Provisional)
Tuesday 15th February 2022 – 1430-1700 hrs	1. Culture update 2. Psychological support to families 3. W&C Governance update
Tuesday 15th March 2022 – 1430-1700 hrs	1. Safety Culture 2. User experience system (UX) 3. Board oversight and learning

5.0 Summary

5.1 Good progress continues to be made against the required actions from the first Ockenden Report (2020), and this work continues at pace. The Ockenden Report Action Plan for the first report has its final completion milestone due in August 2022, as agreed with the Maternity Transformation Assurance Committee and reported to the Operational Delivery Group. The Trust is also putting in place the resources needed to receive and act upon the final Ockenden report, which is expected in Spring 2022.

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 1: Maternity Care													
4.54	A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	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'. A pilot audit of 20 case notes was conducted in May and June. This comprised a series of questions designed to test compliance with a number of actions from the Ockenden Report. It included questions on whether risk assessment was conducted at booking, and at the onset of labour. The audit found that this was compliant in 100% of cases. MTAC were satisfied at their August 2021 to mark this action as 'Evidenced and Assured', but directed that the audit should be repeated as soon as possible with a higher number of cases, and routinely checked going forward, including when Badgernet is in full use (the system will automate the audit).	22/04/21	30/06/21	10/08/21	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	Evidenced and Assured	Completed	Videos and leaflets available plus BabyBuddy app. Key info also provided in handheld notes, which enhanced in partnership with the MVP. The Trust has conducted a review of peer-organisations websites and social media content, and accordingly is working to update its own offering. 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, and minutes from the Birth Options Clinic was sufficient to move this to 'Delivered, Not Yet Evidenced'. A pilot audit of 20 case notes was conducted in May and June. This tested evidence of conversation with healthcare professional to support the decision-making process, written information, documented outcome of the discussions, and number of time a care plan outside of the recommended pathway/national guidance was chosen. Compliance in most cases was around 100%, though only 63% for the provision of written information. This will certainly improve with the introduction of Badgernet, which has mandatory fields to support this and checks to ensure the birthing person has been able to access the information. MTAC approved this action 'evidenced and assured' in their August 2021 meeting, subject to ongoing audit as outlined above.	22/04/21	30/06/21	10/08/21	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 foetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	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. The action was accepted as 'Evidenced and Assured' at the September 21 MTAC meeting, based on the information provided as part of the response to the minimum evidence requirements for IEA 6 (especially 6.1 and 6.2) (which mirrors this LAFL) as set out by NHSE/I. The two dedicated midwives have conducted monthly audits to prove compliance.	13/07/21	31/08/21	10/08/21	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	Evidenced and Assured	Completed	A dedicated SBL project midwife in post, progress against Saving Babies' Lives (SBL) v2 is monitored within scope of Maternity Transformation Plan (MTP); and funding for this post has been secured for a second year. The audits and guideline updates conducted and implemented by this colleague were supported and scrutinised by a specialist senior midwife working on behalf of our partners from Sherwood Forest Hospitals NHS Foundation Trust. They were also subject to oversight and scrutiny from MTAC and the Board of Directors in their relation to Safety Action 6 of Year 3 of CNST and found to be complete and robust. Accordingly, MTAC approved this as 'Evidenced and Assured' in their August 21 meeting.	13/07/21	15/07/21	14/09/21	Hayley Flavell	Shirley Jones	
4.58	Staff must use NICE Guidance (2017) on foetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.	Y	10/12/20	30/04/21	Evidenced and Assured	Completed	FIGO (International Federation of Gynaecology and Obstetrics) guidelines implemented (as opposed to NICE and supported by NHSI/E improvement advisor in 2020). SaTH Foetal 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 foetal monitoring guideline and re-approval by the Quality Operational Committee and QSAC, was sufficient to move this to 'Delivered, Not Yet Evidenced'. Subsequently, at their August meeting, MTAC accepted this as 'Evidenced and Assured' based on the results of the pilot case notes audit, which showed 100% compliance in suitable conversations as part of the intrapartum decision-making process (including a documented discussion of risks, benefits and alternatives in 88% of cases). Continuous foetal monitoring was required (in line with guidelines) for 61% of the cases, and in 100% of these, it was documented that that woman had agreed to the recommendations of continuous foetal monitoring.	22/04/21	30/06/21	10/08/21	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	31/12/21	Delivered, Not Yet Evidenced	On Track	A review of the governance team structure is underway. The Trust has also set up two new divisional governance forums 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. An exception report was created and accepted by MTAC on 10/08/2021, but no deadline has been re-assigned to the deliverable, pending a clearer picture on when the review is likely to be completed. It was noted at MTAC in the November-21 meeting to set the deadline to 31/03/2022 (action moved from 'Off track' to 'On track'). The December-21 MTAC accepted the action as 'delivered, not yet evidenced' based on organisational charts showing the structure of the clinical governance team, showing that the team is now efficiently resourced, and job descriptions detailing the responsibilities covered. It was noted that the partnered review from SFHNHSFT had not yet been received but this did not preclude acceptance of the action.	07/12/21	31/03/22		Hayley Flavell	Shirley Jones	

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	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
4.60	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	31/12/21	Delivered, Not Yet Evidenced	On Track	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. The divisional team is benefitting from the interim leadership of the Trust's Head of Patient Safety, plus the imminent addition of a senior Risk and Governance specialist midwife, to be supported in due course by two further specialist midwives. However, until the above interventions have been carried out and more of the action's sub-tasks have been completed (including the conduct of an assurance exercise and cross-referencing between Datix and MEDWAY), the MTPG cannot yet advise MTAC to approved this action as 'Delivered, Not Yet Evidenced'. As with 4.59, an exception report was created and accepted by MTAC on 10/08/2021, but no deadline has been re-assigned to the deliverable, pending a clearer picture on when the review is likely to be completed. It was noted at MTAC in the November 21 meeting to set the deadline to 31/03/2022 (action moved from 'Off track' to 'On track'). The December-21 MTAC group accepted the action as 'delivered, not yet evidenced' based on provision of SOAG draft SOP, and evidence that new quality governance framework in place. MTAC directed that for this to progress further they require evidence that the datix/Medway and Badgernet incident reporting cross-referencing is being regularly conducted.	07/12/21	31/03/22		Hayley Flavell	Shirley Jones	
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	Evidenced and Assured	Completed	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'. This decision was followed up as part of the pilot case-notes audit, which found that, of the 20 sets of notes audited, 8 women had been referred to a consultant. In all cases (100%), this was to the correct Consultant based on the primary condition, the appointment was made within CRT guidelines, and the women did indeed attend the appointment. The highest grade of doctor who saw the women was, in each case, a consultant. Based on this, MTAC approved the action as 'Evidenced and Assured' in their August meeting. The action must be the subject of ongoing audit as described above.	22/04/21	31/05/21	10/08/21	Hayley Flavell	Shirley Jones	SaTH NHS SharePoint

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.62	There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	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. An audit if handover notes proved appropriate inclusion of MDT colleagues, including for obstetric anaesthesia. 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. Subsequently, thanks to LMNS funding, the requisite SIM equipment has been purchased. The latest PrOMPT courses (including train-the-trainer) have been acquired from MTP funds and will form part of CNST Safety Action 8 for year 4. Accordingly, and subject to the usual ongoing audit requirements, MTAC approved this action as 'evidenced and assured' in their August meeting.	22/04/21	30/06/21	10/08/21	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	This action is in place - 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'. Since the above direction was provided by MTAC, the MTP has not yet been able to secure the evidence required. An exception report has been prepared and was accepted by MTAC on 10/09/2021, agreeing a revised evidence date of 28-Feb-22 based on the point that the case notes audit tool is being revised, and a subsequent audit will be conducted as soon as possible.	22/04/21	28/02/22		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
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 as the next step for evidencing. Accordingly, a specific section (Question 15, parts a-l) on the case notes audit tool was created. However, the results of the pilot audit were inconclusive. The tool has been amended to increase clarity, and the next audit will be run as soon as possible. Depending on the findings to this part of the audit, MTPG will propose an change to the delivery status for this action at a future meeting. A exception report has been prepared, with a request to extend the evidence date to Feb-22. This was accepted by MTAC at their September meeting.	22/04/21	28/02/22		Hayley Flavell	Shirley Jones	SaTH NHS SharePoint

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.65	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 are in place, but the Trust does not yet have a named consultant lead (although consultants are currently offering this care collectively). Funding has been agreed for the rainbow clinic, of which the consultant will be a part. 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 (Foetal 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. This action has already been the subject of one agreed deadline amendment (from June to July 21 for delivery, and September 21 for evidence). As the action has not yet been delivered, as at mid-September, a further exception report has been prepared and submitted to MTAc at their September 21 meeting, with a request to amend the delivery and evidence dates to February 2022 in line with LAFL 4.66.		28/02/22		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	28/02/22	Not Yet Delivered	On Track	14/09/2021: The Trust has conducted a self-assessment regarding the level to which the pathway has been adopted. This indicates a high-level of compliance. However, it has not been externally validated. Sands (the stillbirth and neonatal death society) have been commissioned to conduct a review of bereavement care at SaTH; the will visit the Trust on 9-10th November. Subject to their advice, SaTH will engage Sands for further development guidance and support. The Trust has in place two specialist bereavement midwives. Consultant-led bereavement care is in place, however as yet there is no named consultant lead. Funding for the rainbow clinic has been approved. Once this is in place, and the consultant lead is named; it is likely MTP will be able to advise MTAC to consider this action 'Delivered, Not Yet Evidenced'. MTAC accepted an exception report to this effect at their August 21 meeting and agreed a revised date for both delivery and evidencing of February 2022.		28/02/22		Hayley Flavell	Shirley Jones	

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 2: Maternal Deaths													
4.72	The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	The escalation policy already in place; it was updated in November 2020 to describe situations where Consultants must be in attendance. A process is in place to assess competencies of all middle grade doctors, not just O&G trainees. At their meeting on 22/04/2021, MTAC accepted status 'Delivered, Not Yet Evidenced' based on the escalation process poster that is displayed on the wards. In order to progress to 'Evidenced and Assured Status', the committee next wish to see the completed guidelines / SOP document, and an audit of adherence to them. This formed part of the pilot case notes audit, but the evidence regarding this section (Q7 c and d and Q8) was inconclusive. Accordingly, the wording of the associated questions within the audit tool has been made more specific and explicit, and the next round of audit will be commenced as soon as possible. In the meantime, the deadline having been missed, an exception report has been prepared and was accepted by MTAC at their September meeting.	22/04/21	28/02/22		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~~ New date to be agreed	Not Yet Delivered	Off Track (see exception report)	SaTH's 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. MTAC noted at their August 21 meeting that completion of this action is reliant on several external dependencies that are not within SaTH's control to implement. The main one is the establishment of the regional Maternal Medicine Specialist Centres. The original (self-imposed) June deadline having been missed, MTAC were provided with an exception report, which they accepted - including the proposal that the delivery and evidence dates be left blank until a clearer timeline from the regional Clinical Network is available. However, in the meantime, the service must ensure that all relevant guidelines covering care for women with co-morbidities (for example cardiac conditions) should be reviewed, and where necessary, updated. Furthermore, the service should draft guidelines for referral to specialist maternal medicine centres (acknowledging that the guidelines are the prerogative of the Network), that can be finalised once the centres are nearing implementation.				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. Of note, the Ockenden report does not specify 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). However, the MTP group have not yet been able to secure audit evidence that the appropriate consultant is being nominated for all such cases requiring this level of care. The case notes audit (the tool for which is currently being revised, following the pilot audit and in preparation for the imminent re-audit) should help to evidence this. However, the action having missed its intended (self-imposed) deadline for evidencing, an exception report has been prepared and was accepted by MTAC at their September meeting.	22/04/21	28/02/22		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
Local Actions for Learning Theme 3: Obstetric Anaesthesia													
4.85	Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.	Y	10/12/20	31/03/22	Delivered, Not Yet Evidenced	On Track	Anaesthetists participating in MDT ward rounds and running / participating in MDT emergency obstetrics course simulation centre, approximately 3 x per year. The Lead obstetric anaesthetist is a key facilitator in weekly in situ simulation training and the service has recently recruited a new anaesthetist with deep experience in sim training design to further support. The training includes obstetricians, anaesthetists of all grades, ODPS & other theatre staff and midwives of all grades (including students and co-ordinators). More than 90% of Obstetric anaesthetists completed the online PrOMPT course by April 2021, and there is planned Involvement of anaesthetists in PrOMPT training for the remainder of 2021 and into 2022 – both as facilitators and participants. The service has also identified an obstetric anaesthetic consultant to join the weekly teaching faculty. Given the complexity, scale and challenges of fully meeting these actions, MTAC, at their August meeting, accepted the proposal mooted at the July ORAC, that all actions relating to Obstetric Anaesthesia should have the delivery and evidence deadline extended to March 2022. MTAC took assurance at their Dec-21 meeting that the comedical directors had met with the obstetric anaesthetist lead and her colleagues, and were providing direct support to ensure the Ockenden actions relating to anaesthesia are being adequately resourced. The December-21 MTAC accepted the action as 'delivered, not yet evidenced', on the condition that the PROMPT compliance record showing >90% attendance was updated. In the January-22 MTAC the action was revised as the PROMPT compliance record for the March-21 period showed 89.5% rather than >90%. The committee agreed for the status to remain 'delivered, not yet evidenced'.	07/12/21	31/03/22		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	31/03/22	Delivered, Not Yet Evidenced	On Track	There is good engagement with anaesthetics department, but this is over-dependent on the contributions of the obstetric anaesthesia lead, and must therefore be broadened. Two consultants have been appointed to take on this role, and evidence of this will be shared in due course. The consultant Anaesthetics Lead for Obstetrics is working closely with Clinical Director for obstetrics to ensure that anaesthetics staff are fully-embedded in the delivery of safe and effective care. The lead is also a principal office in the planned establishment of a high-dependency service for mothers within maternity / neonatal care - this is a multi-disciplinary initiative. The December-21 MTAC accepted this action as to 'delivered, not yet evidenced' based on evidence that QI and risk leads are now in place within obstetric anaesthesia, multiple MDT simulation courses and skills drills have been carried out over the last 12 months, and an anaesthetics education lead is in place to share learning across the multidisciplinary team. MTAC require evidence of inclusion of anaesthesia in the rolling audit plan as part of the requirement to move this action to 'evidenced and assured'.	07/12/21	31/03/22		Hayley Flavell	Janine McDonnell	

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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
4.87	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	31/03/22	Delivered, Not Yet Evidenced	On Track	Annual audit cycle in regards to Royal College of Anaesthetists (RCoA) Guideline audit currently in place (covers theatre and epidural practice). The Guidelines review that was started this year is now almost complete, with two final sets to be finished. The audit of this is not yet in place, but will partly covered by the bespoke Ockenden Report Case Notes audit tool, with further resources to be provided as needed. Noting the scale of this task and the associated resources challenges, MTAC agreed a deadline extension to March 2022 for this task, adding a requirement for a formal update no later than December 2021. The December-2021 MTAC accepted this action as 'delivered, not yet evidenced' based on evidence of a guidelines update alert tracker, a nominated guidelines lead, and evidence of an audit plan.	07/12/21	31/03/22		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	31/03/22	Delivered, Not Yet Evidenced	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” has been completed and published on the SaTH intranet document library. Compliance of completed CPD sessions is in progress of being collated and audited by a member of the anaesthetics team. As with all of the actions derived from this section of the report, in the light of the complexity and scale of this action and the associated challenges, MTAC approved a revised delivery and evidence date of 31/03/2022 at their August 21 meeting, but require a formal progress update by their December meeting. MTPG proposed this action as 'evidenced and assured' at the December-21 MTAC meeting based on evidence that the guideline had been published in the Trust portal; however, MTAC accepted the action as 'delivered, not yet evidenced' only, as they require evidence of governance approval prior to upload and also proposed a minor change in wording.	07/12/21	31/03/22		Hayley Flavell	Shirley Jones	Link to SaTH Anaesthetics Document Library
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	31/03/22	Delivered, Not Yet Evidenced	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. The QI task requires a significant level of audit against multiple data points; this represents a significant challenge in the light of limited resources. The Trust's QI team have agreed to support the implementation of the methodology, but only once the data set has been secured. Accordingly, and as with all of the actions derived from this section of the report, in the light of the complexity and scale of this action and the associated challenges, MTAC approved a revised delivery and evidence date of 31/03/2022 at their August 21 meeting, but require a formal progress update by their December 2021 meeting. The December-2021 MTAC accepted this action as 'delivered, not yet evidenced' based on evidence of partial completion of ACSA 189 standards audit, a nominated audit lead within anaesthesia and a co-produced bespoke Ockenden case notes audit tool which is currently being completed.	07/12/21	31/03/22		Hayley Flavell	Shirley Jones	

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4.90	The Trust must ensure appropriately trained and appropriately senior/experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.	Y	10/12/20	31/03/22	Not Yet Delivered	On Track	Obstetric Anaesthetist expertise is incorporated to regular Datix reviews and these colleagues also provide regular input to 'Human Factors' investigations. The Trust recognises the need for Anaesthetics consultants (other than the obstetrics anaesthesia lead) to dedicate SPA time to Obstetrics in addition in order to progress this action, and this will require audit evidence. It represents a significant challenge to the service in its current format, hence MTAC approved a revised delivery and evidence date of 31/03/2022 at their August 21 meeting, but require a formal progress update by their December meeting.		31/03/22		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	SaTH have proved compliance Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, safety action 8, which governs multi-disciplinary training for emergencies including neonatal resuscitation. A simulation course is held 3 x per year, and In situ simulation training conducted weekly. 90% of obstetric anaesthetists submitted evidence of completion of the online PrOMPT course by April 2021. MTAC accepted this as 'Delivered, Not Yet Evidenced' at their first meeting in April 2021, 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. It was agreed at this time that the demonstrated fulfilment of CNST MIS Safety Action 8 will move this to 'Evidenced and Assured Status', however attendance records had not been secured in time for the September MTAC meeting, and will therefore be shared at the October meeting, at which point it is likely MTPG can advise MTAC to accept the action as 'evidenced and assured'. The December-2021 MTAC rejected the groups proposal for the status to change from 'delivered, not yet evidenced' to 'evidenced and assured'. The committee advised that further evidence is required showing that all theatre staff are involved in the MDT training, before the status can be moved to 'evidenced and assured'.	22/04/21	31/03/22		Hayley Flavell	Will Parry-Smith	SaTH NHS SharePoint

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Local Actions for Learning Theme 4: Neonatal Service													
4.97	Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Roll out of combined medical and nursing notes to Neonatal Unit (NNU) was implemented soon after receipt of the Ockenden Report, in Q4 2020/2021. The NNU undertook to ensure information on joint medical and nursing note keeping held on all staff induction. Adherence to the above is monitored via an audit, designed and conducted by one of our consultant neonatologists. MTAC approved this as 'Delivered, Not Yet Evidenced' in April 2021 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. Having been provided with the evidence of subsequent audits proving compliance, MTAC accepted the action as 'Evidenced and Assured' in their September meeting. To further embed the action, NNU will repair a business case for Neonatal Badgernet EPR, which will align efficiently with the system that was introduced to Maternity Services in August 2021.		30/04/21	14/09/21	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	Evidenced and Assured	Completed	Confirmation was received on 16-Aug-21 from Dr R Kennedy (Associate Medical Director NHSE/I Midlands) that, following his discussion with the ODN Medical Leads (neonatologists) and they are in agreement that compliance with the WM ODN Pathway framework, BAPM Guidance on Good Practice for LNUs and the NHSE Commissioning Guidance for Neonatal Care is sufficient. Additionally, he recommended a local SoP be developed which sets out escalation, triggers for level three unit consultation and referral, compliance with which should form part of the audit schedule. The SOP is in place. Based on this, MTAC accepted this action as 'Evidenced and Assured' in their September meeting, with the proviso that the audit of adherence to the SOP should form part of the ongoing audit schedule.	14/09/21	30/06/21	14/09/21	Hayley Flavell	Shirley Jones	
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	Evidenced and Assured	Completed	The issue of a split Tier 2 rota due to the size of the paediatric department is being developed actively. The neonatal unit is compliant with BAPM staffing and activity for medical/ANNP staff with a combined rota but the activity and size of paediatrics has led the Deanery to recommend a split Tier 2. SaTH have now recruited a seventh Consultant Neonatologist, with an expected start date of January 2022. Given evidenced compliance with the BAPM guidelines (externally checked and validated by Dr Kennedy, Medical Director NHSE/I Midlands), and assurance that the recruitment of the seventh consultant has been conducted, MTAc accepted this action as 'Evidenced and Assured' in their September meeting.	12/01/21	31/10/21	14/09/21	Hayley Flavell	Janine McDonnell	

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4.100	There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.	Y	10/12/20	31/03/21	Not Yet Delivered	On Track	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. However, the plans stalled as SaTH were not able to release consultants for attachments at the same time as maintaining a safe rota: a seventh consultant would be needed for this. Accordingly, the action was moved back to 'Not Yet Delivered' status. SaTH has subsequently recruited a seventh neonatal consultant and reconfirmed agreement from the Neonatal Departments at Stoke and Birmingham Women and Children's Hospitals to accept our neonatal staff (both consultants and Advanced Neonatal Nurse Practitioners) on rotational attachments (2 weeks per year). This has been introduced to consultants' Job Plans. However, this consultant will not be able to start at the Trust until January 2022. MTAc accepted an exception report detailing this at their September meeting, and agreed a deadline extension to February 2022.		28/02/22		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	28/02/22	Not Yet Delivered	On Track	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 MTAC agreed that the recommendation for this action to remain 'not yet evidenced' at their November-21 meeting. An exception report will be produced with the aim of extending the deadline to Feb-22. MTAC accepted the exception report and agreed to extend the deadline to Feb-22, allowing time for the SOP demonstrating how the Trust reports the Maternity and neonatal dashboards both internally and externally via the LMNS, to be finalised and embedded effectively.		28/02/22		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 foetal death, maternal death, neonatal brain injury and neonatal death.	Y	10/12/20	31/05/21	Evidenced and Assured	Completed	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. Subsequently, an audit was carried out to check that an external specialist had been a panel member at the relevant meetings was conducted and proved compliance. MTAC therefore accepted the action as 'Evidenced and Assured' at their August meeting.	13/07/21	31/07/21	10/08/21	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	TBC	Not Yet Delivered	Not Started	SaTH have embarked on a review of membership of LMNS with a view to joining a larger LMNS - this includes a review of current structure and work streams to ensure adequate and effective oversight. LMNS and CCG have implemented t the Perinatal Clinical Quality Surveillance Model, which includes SaTH, and have supplied 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. However, the NHSEI minimum evidence requirements for IEAs, published in May 2021, do not allude to this specific action. Given the large number of external dependencies on which the action is contingent, and to avoid arbitrary deadlines, MTAc agreed that the delivery and evidence date should be amended to 'to be confirmed', pending clarity on this process.		TBC		Hayley Flavell	Hayley Flavell	
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	TBC	Not Yet Delivered	Not Started	SATH currently a single trust LNMS. Issue raised with NHSI/E regional office. Review of membership of LMNS with a view to joining a larger LMNS. Review of current structure and work streams to ensure adequate effective oversight. 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. At their August meeting, MTAc acknowledged that this is a major strategic decision for SaTH and is also dependent on a significant number of external deliverables and partners. In order to avoid arbitrary deadlines, MTAC agreed that the delivery and evidence dates for this should be marked as 'to be confirmed', pending greater clarity. All actions with no assigned date will be reviewed on at least a monthly basis to check whether enough clarity has been obtained to be able to move forward with the action.		TBC		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	Evidenced and Assured	Completed	MTAC accepted this as 'Evidenced and Assured' at their August-21 meeting, based on the evidence provided: CCG Terms of reference and published list of members; showing that the LMNS chair is a member of the CCG's board. Subsequently, SaTH's Maternity and Neonatal Safety Champion now benefits from the addition of the CCG's Senior Quality Lead and Patient Safety Specialist, further strengthening the promotion of the safety agenda between CCG, LMNS and the Trust.	31/01/21	30/06/21	10/08/21	Hayley Flavell	Hayley Flavell	
1.6	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.	Y	10/12/20	28/02/22	Not Yet Delivered	On Track	SaTH recognise the need to review and strengthen SI reporting process to Trust Board and LMNS - a quarterly report to Trust Board, using peer as example of reporting process, must be part of this. 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 remained 'Not Yet Delivered'. At MTAC's August meeting, the committee still felt this action is not being met sufficiently. At their September report, they agreed a further exception report requesting a delivery and evidence extension to February-22 to give time for the ongoing governance review to be completed and embedded (this action will form a key part of the review). 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		28/02/22		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.

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 2: Listening to Women and Families													
Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	TBC	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. This not being within SaTH's control, there is no requirement or benefit in marking the action as 'Off Track', further, MTAC agreed at their August meeting to amend the delivery and evidence dates to 'to be confirmed' pending clarity on a national level as to when and how these roles will be created.		TBC		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	TBC	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'.		TBC		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	SaTH has a Non-Executive Safety Champion in post with oversight of Maternity Services, and an Executive Safety Champion in post – Trust Executive Medical Director (Interim co-Medical Directors currently representing). All of these post-holders are active members of the Maternity and Neonatal Safety Champions Group, and participate on a monthly basis in this group's 'walkabouts' and meetings. The actions was 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.	22/05/2021	30/04/21	08/06/21	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	TBC	Not Yet Delivered	On Track	Action to be discussed with CQC at relationship meeting. It is understood the MVP were not contacted by CQC at their most recent inspection of SaTH. 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'; there is no reason or benefit in marking 'Off Track' as the action is not within our control and there is no escalation route. MTAC agreed at their August meeting that the delivery and assurance dates should be left 'to be confirmed' until greater clarity can be obtained from CQC and other parties.		TBC		Hayley Flavell	Shirley Jones	

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IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 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	Evidenced and Assured	Completed	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 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. The approved MDT funding bid and MTP training allocation are being implemented - for example, SaTH has 25 places on both Baby Lifeline's Management of the Sick and Deteriorating Woman and Learning From Adverse Events courses in November. SaTH has also invested in enhanced Clinical Practice Educator roles and training backfill for midwives and consultants as well as PA to deliver PROMPT and CTG training. Upon confirmation and evidencing that LMNS are receiving quarterly reports on this activity, the action will be recommended for acceptance as 'Evidenced and Assured'. The December-2021 MTAC accepted the action as 'evidenced and assured' based on NHSE/I minimum evidence required, score of 100%.	13/07/21	30/10/20	07/12/21	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	Evidenced and Assured	Completed	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 must a daily sheet that records the ward round and a Monthly audit of attendance at Ward Rounds has been introduced. SaTH has recruited a number of additional consultants over the summer of 2021, with more recruitment ongoing. 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. Based on evidence of the audit mentioned above, MTAC accepted the action as 'Evidenced and Assured' in their August 21 meeting.	22/04/21	30/06/21	10/08/21	Hayley Flavell	Guy Calcott	SaTH NHS SharePoint
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	Evidenced and Assured	Completed	SaTH have 13 associated proposed business cases comprising investment of up to £5.1m across all Women and Children's specialties with a further £0.3m provided by the LMNS. Included in this request is up to 102 members of staff, of which 55 would be permanent additions. Of this, the Maternity Transformation Programme has been allocated £1.35m of which £190k (14% of the total) has been set aside for training, the bulk of which is multi-disciplinary. Further, the Trust has been awarded £55k of part of the national response, which has been ring-fenced for PrOMPT, foetal monitoring training and instruction, and associated backfill for clinical time. Al of this is being reported regularly to MTAC and has been approved by the Director of Finance. Accordingly, MTAC accepted this as 'Delivered and Evidenced' at their August 21 meeting.	10/08/2021	30/09/21	10/08/21	Hayley Flavell	Hayley Flavell	

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IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 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	Evidenced and Assured	Completed	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. MTAC accepted this as 'Evidenced and Assured' at their November-21 meeting, based on the 100% rating from NHSEI in their minimum evidence return. However, the group requested further evidence of audit to be circulated via email.	13/07/21	29/10/21	04/11/21	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. Foetal 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 NHSEI minimum evidence 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. MTAC agreed that the recommendation for this action to remain 'not yet evidenced' at their November-21 meeting. MTAC accepted the exception report and agreed to extend the deadline to Feb-22 in the December-21 meeting, in order to complete the data collection and data analysis for the Ockenden-specific case notes audit and review.	13/07/21	28/02/22		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	30/04/22	Not Yet Delivered	On Track	The location of the regional centres has been divided upon by the clinical network, but the centres have not yet been set up. SaTH will act to formalise connections with specialist maternal medical centres once established This action was one of six that MTAC, at their August 21 meeting, accepted as being outside of the direct control or ability of SaTH to implement - the specialist centres are being established under the oversight of the regional clinical network. Therefore, MTAC agreed that the delivery and evidence dates should be set as 'to be confirmed' pending an update from the network. This is to be monitored closely by divisional clinical and managerial leads, and as soon as the details are known, the action plan must be updated and implemented with urgency. Given that we do not have an clear indication of timeline for this action, there is no benefit in marking it 'off track' hence status has reverted to 'on track'. MTAC agreed that the recommendation for this action to remain 'not yet delivered' at their November-21 meeting. Deadline date to be agreed. MTAC accepted the exception report and agreed to extend the deadline to Apr-22 in the December-21 meeting, as the Maternal Medicine Centres will be expected to go live in April-22.		30/04/22		Hayley Flavell	Guy Calcott	
4.4	This must also include regional integration of maternal mental health services.	Y	10/12/20	30/06/21	Delivered, Not Yet Evidenced	On Track	Obstetric Clinical Director engaged with network on this topic. Perinatal mental health guidelines and referral pathways have been shared as evidence, and this was accepted as 'Delivered, Not Yet Evidenced' in April 2021. Since then, SaTH has become an early implementor of the Perinatal Mental Health Service, under the leadership of one of the Transformation Midwives. The clinic is now in the course of being set up, with specialist midwives and psychologists recruited. Once this has had time to establish itself, an update will be shared (to include details of how it is integrated regionally); this is likely to be suitable evidence to move the action to 'Evidenced and Assured'. MTAC agreed that the recommendation for this action to remain 'not yet evidenced' at their November-21 meeting. An exception report will be produced with the aim of extending the deadline to Feb-22. The December-21 MTAC accepted the exception report and agreed to the recommendation of unlinking IEA 4.3 and 4.4, and to re-evaluate the delivery date in Jan-22 MTAC.(leaving as Aug-22 in the meantime)	20/04/21	30/08/22		Hayley Flavell	Guy Calcott	

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Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy													
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.													
5.1	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	For Intrapartum care, high risk women will have risk re-assessed hourly throughout labour with "fresh eyes" review. A separate risk assessment tool is being developed for women receiving low risk care in all birth settings to clearly document a regular review of risk status. Documentation contained within each woman's handheld PSCP/notes requires risk assessment to be reviewed at each contact 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 specified that 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. This latter evidence was still not available as of the MTAC meeting in September. Accordingly, an exception report was provided. This explained that the evidence collated on this point from the pilot Ockenden Report case notes audit was inconclusive, and that accordingly the tool is in process of being modified preparatory to a second audit as soon as possible. This combines with the implementation of Badgernet in mid-August 21 to give confidence that the evidence will be available in the next few weeks. However, a significant deadline extension (to February 2022 from June 2021) for evidencing this was requested, to ensure the audit data can be analysed and acted upon before reporting back to the committee.	22/04/21	28/02/22		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 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). The audit evidence to support this action's move to 'Evidenced and Assured' status was still not available as of the MTAC meeting in September. Accordingly, an exception report was provided. This explained that the evidence collated on this point from the pilot Ockenden Report case notes audit was inconclusive, and that accordingly the tool is in process of being modified preparatory to a second audit as soon as possible. This combines with the implementation of Badgernet in mid-August 21 to give confidence that the evidence will be available in the next few weeks. However, a significant deadline extension (to February 2022 from June 2021) for evidencing this was requested, to ensure the audit data can be analysed and acted upon before reporting back to the committee.	22/04/21	28/02/22		Hayley Flavell	Guy Calcott	SaTH NHS SharePoint

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Immediate and Essential Action 6: Monitoring Foetal 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 foetal 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 foetal wellbeing * Consolidating existing knowledge of monitoring foetal wellbeing * Keeping abreast of developments in the field * Raising the profile of foetal wellbeing monitoring * Ensuring that colleagues engaged in foetal wellbeing monitoring are adequately supported * Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Lead obstetrician in place with allocated time and job description – 1 SPA per week incorporating PROMPT, Foetal 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. MTAC accepted the action as 'Evidenced and Assured' at their September meeting based on the evidence provided as part of the NHSE/I minimum evidence requirements for IEAs. The committee did note, however, that formal response from NHSE/I as to the level to which this evidence supports proven completion of the action is still pending, and this must be factored in upon receipt. Further, ongoing evidence of the CTG training and activities will be expected (as with all of the Ockenden Report actions).	13/07/21	31/08/21	14/09/21	Hayley Flavell	Shirley Jones	
6.2	The Leads must plan and run regular departmental foetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	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. The two foetal monitoring midwife leads have now been in post for several months and have provided evidence of a multiple well-attended foetal monitoring training days throughout the spring and summer, and plans for more to follow soon. Examples of foetal 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'. MTAC accepted this as 'Evidenced and Assured' at their November-21 meeting, based on the 100% rating from NHSEI in their minimum evidence return.	13/07/21	30/10/21	04/11/21	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	Evidenced and Assured	Completed	SaTH benefits from the close oversight of the SBL care bundle by a senior project midwife (1.0 WTE) who will remain in the post for at least another 24 months. The Trust declared compliance with all required elements of the Saving Babies Lives v2 Care Bundle for the year three CNST MIS scheme. The evidence for this was robustly tested at MTAC and other governance forums as well as specialist senior midwifes from NHSE/I and our Sherwood Forest Hospitals NHS Foundation Trust partners. MTAC therefore accepted the action as 'Evidenced and Assured' at their August 21 meeting.	13/08/21	15/07/21	13/08/21	Hayley Flavell	Shirley Jones	

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Immediate and Essential Action 7: Informed Consent													
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). Digitalisation of patient records, through the implementation of the Badgernet system (now introduced) will ensure this data is available in digital format. The system can also alert clinicians if a mother has not accessed the information, prompting a discussion as to whether further support is needed. The Communication and Engagement workstream includes MVP and patient representation; our MVP colleagues conducted a comparison of SaTH's online provision with that of other Trusts; this will inform ongoing digital improvements as part of the MTP. MTAC approved this to 'Delivered, Not Yet Evidenced' status based on the evidence referenced for LAFL 4.55, including online and handheld information. However, this action is slightly different from the corresponding LAFL as it emphasises the different points of the pregnancy, and the Trust is developing new leaflets on these specific areas in partnership with the MVP. Therefore, at their September meeting MTAC accepted an exception report explaining that the results on this point from the pilot case notes audit were inconclusive (the tool is being amended accordingly). Further, the digital updates have not been significantly progressed, and finally, SaTH have not yet agreed a method by which we can test service user feedback, via MVP data and with their input and support. For this reason, an evidence deadline extension to February 2022 was accepted.	10/08/21	28/02/22		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	Delivered, Not Yet Evidenced	On Track	Work is on-going as part of the Antenatal Care Pathway sub-project. The Ockenden Report case notes audit and automatic audits from the Badgernet system will help us to ascertain whether the mother and partner / family have received and consumed the information as intended. MTAC decided in their meeting on 22/04/2021 that this should remain 'Not Yet Delivered', as they were not satisfied the Trust has 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. MTAC accepted an exception report with revised delivery date 30/04/21 to 31/07/21 and evidence date from 30/06/21 to 30/09/21. In their August 21 meeting the accepted the action as 'Delivered, Not Yet Evidenced' based on audit data, minutes from the Birth Options clinic, and evidence of greater liaison and co-production with the MVP, including the new 'UX System'. To move the action to 'evidenced and assured', MTAC require proof that women report, via MVP channels, that they feel empowered to make decisions about their care. The evidence deadline has not changed, because it is feasible to have this evidence ready for the next MTAC meeting (October), in which case the missed deadline will only be slightly out of tolerance. By this time, it is also likely the Trust will have received formal feedback as to the level to which the evidence submitted to the NHSE/I minimum evidence portal for IEAs is deemed by that organisation to have met the standard. Exception report was accepted at the Oct-21 MTAC meeting to extend the deadline to Feb-22.	10/08/21	28/02/22		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 dedicated PALS officer has been appointed to Maternity Services to offer in-reach and provide real time feedback. MTAC approved this to 'Delivered, Not Yet Evidenced' in their April 21 meeting, 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. To move the action to 'evidenced and assured', MTAC require proof that women report, via MVP channels, that they feel empowered to make decisions about their care. The evidence deadline has not changed, because it is feasible to have this evidence ready for the next MTAC meeting (October), in which case the missed deadline will only be slightly out of tolerance. By this time, it is also likely the Trust will have received formal feedback as to the level to which the evidence submitted to the NHSE/I minimum evidence portal for IEAs is deemed by that organisation to have met the standard. It was agreed (without a formal exception report) that this action could have an extended evidencing deadline to Feb-22 as to answer it fully we require evidence from the MVP that women feel that their choices were respected and supported, this will be conducted by an MVP-led focus group comprising women who have attended the birth options clinic, this clinic is quite new - hence, we require this extension to allow a large enough dataset to accrue.	22/04/2021	28/02/22		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.

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 deadline 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	
Guy Calcott	Obstetric Consultant	Lead: Clinical Quality and Choice Workstream	
Claire Eagleton / Vicki Robinson	W&C HRBP	Co-Leads: People and Culture Workstream	
Shirley Jones	Interim Head of Midwifery	Lead: Risk and Governance Workstream and Maternity Improvement Plan	
William Parry-Smith	Obstetric Consultant	Lead: Learning, Partnerships and Research Workstream	
Mei-See Hon	Clinical Director, Obstetrics	Lead: Communications and Engagement Workstream	