The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee
AGENDA

Meeting Details

Date **Tuesday 15th March 2022**
Time **14.30 – 16.45**
Location **Via MS Teams – to be live streamed to the public**

AGENDA

Item No.	Agenda Item	Paper / Verbal	Lead	Required Action	Time
2022/10	Welcome and Apologies Welcome to the members of the Board of Directors Welcome to Claire Roche – Director of Nursing and Midwifery – Powys Teaching Health Board Welcome to Dr Patricia Cowley, Clinical Director for Neonates	Verbal	**Chair**	Noting	14.30 (15 min)
2022/11	Declarations of Interest relevant to agenda items	Verbal	**Chair**	Noting	
2022/12	Minutes of meeting on 15th February 2022 Matter Arising: Update on the publication of the second Ockenden Report	Enc 1.1 Verbal Verbal	**Chair** **Mike Wright** Programme Director, Maternity Assurance	Approval For information	
2022/13	The first Ockenden Report (2020) 1. Responses to Questions from Stakeholders: Dr Anthea Wilson, Powys Community Health Council 2. Progress on the implementation of the actions arising from the first Ockenden Report (2020): • 27 Local Actions for Learning • 7 Immediate and Essential Actions (comprising 25 sub-actions) Q&A Session	Presentation	**Martyn Underwood** Medical Director Women and Children's Division **Mei-See Hon** Clinical Director Obstetrics Women and Children's Division **Annemarie Lawrence** Director of Midwifery Women and Children's Division **Mr Tom Baker** Deputy Director of Operations Women and Children's Division	Presentation and Discussion	14:45 (90 mins)

2022/16	Observations and comments from relevant stakeholders and groups representing service users: • What have the stakeholders and groups representing service users heard so far in the first four meetings? • What reflections and observations do they have and wish to share at this stage? 3. Based on where the work of the Committee so far, what would stakeholders wish to see in the future meetings relating to the Ockenden Report action plan?	Verbal	Chair All	Discussion	16:15 (15 min)
2022/17	Discussion and reflection: • Key messages for the Board of Directors • Key messages for service users - women and families • Any other steps we need/wish to take •	Verbal	Chair All	Discussion	16:30 (15 min)
2022/18	Meeting closes Date of Next Meeting: No meetings scheduled for April or May 2022. Further meetings will be established subject to the requirements/outcomes arising from the second Ockenden Report.	Verbal	Chair		Finish 16:45

Enclosures:

<u>March 2022 – Ockenden Report - Board of Directors Reports:</u>

- Ockenden Report Progress Report DoN vF
- BoD February 2022 - Ockenden Report Action Plan Progress Update

The Shrewsbury & Telford Hospital NHS Trust

Ockenden Report Assurance Committee meeting in PUBLIC

Tuesday 15th February 2022 via MS Teams

Minutes

NAME	TITLE
MEMBERS	
Dr C McMahon	Co-Chair
Ms J Garvey	Co-Chair
Dr J Jones	Acting Medical Director (Trust)
Mr A Bristlin	Non-Executive Director (Trust) and Non-Executive Director lead for Maternity Services
Professor Trevor Purt	Non-Executive Director (Trust) and Chair, Audit and Risk Committee
Ms H Flavell	Director of Nursing (Trust)
Dr A Wilson	Member, Powys Community Health Council
ATTENDEES	
Mr M Wright	Programme Director Maternity Assurance (Trust)
Mr T Baker	Senior Project Manager Maternity Transformation Programme (Trust)
Ms J Bolton	Interim Matron Community and MLU
Dr M-S Hon	Clinical Director – Obstetrics / Maternity (Trust)
Ms Rhia Boyode	Director of People and Organisational Development
Ms C Eagleton	Matron Inpatient Services
Mr K Haynes	Independent Governance Consultant
Ms Cristina Knill	Senior Project Manager - Maternity Transformation Programme
Ms Annemarie Lawrence	Directory of Midwifery (Trust)
Ms L MacLeod	Maternity Voices Partnership Development CoordinatorTelford & Wrekin
Ms Sharon Fletcher	Perinatal Quality Lead and Patient Safety Specialist, Shropshire, T&W CCG and LMNS
Ms Julie Plant	Divisional Director of Nursing – Women and Children's
Ms Vicki Robinson	Interim People & OD Business Partner for Women's and Children's Services
Ms Eve Davies	
Ms Julie Richards	
Mr Simon Meighen	
Ms Kath Preece	Assistant Director of Nursing, Quality Governance
APOLOGIES	
Mr M Underwood	Divisional Medical Director for Women & Children (Trust)
Mrs Louise Barnett	Chief Executive (Trust)
Ms Lynn Cawley	Healthwatch

No. 2020	ITEM	ACTION
Procedural Items		
010/22	**Welcome, introductions and apologies**. The Co-Chair, Jane Garvey welcomed everyone to the meeting and noted all apologies.	
011/22	**Declarations of Conflicts of Interests** There were no conflicts of interest to be noted.	
012/22	**Minutes of the previous meeting and matters arising** The minutes of the previous meeting of 18th January 2022 were noted and approved as a correct record. Ms. Jane Garvey asked for an update on the expected date of the publication of the second Ockenden Report. Mike Wright confirmed that whilst not official, it is understood the date will be 22nd March 2022, with the Trust receiving a copy for its consideration the day before. He also explained that work was ongoing to prepare staff and current service users for its publication. Ms. Garvey asked Ms Hayley Flavell about the CQC 2021 Maternity Services Survey. Ms Flavell explained that the national survey included 122 NHS Trusts with responses from more than 23,000 women. The sample for the survey was drawn from women who gave birth in February 2021 during the third national Covid-19 lockdown. The survey asked women about their experiences of care at three different stages of their care – antenatal, labour and birth, and postnatal care. Ms Flavell explained that the survey report assessed the variation in trust results for questions on labour and birth, and care on the ward after birth, as women can receive antenatal and postnatal care from different providers. In the analysis (http://www.cqc.org.uk/maternitysurvey) trusts were identified where women's experiences were better, or worse, than expected when the results for the survey were compared across trusts. Ms Flavell went on to explain that each trust has been categorised into one of five bands – 'much worse than expected,' 'worse than expected,' 'about the same,' 'better than expected' or 'much better than expected.' Pleasingly, Ms Flavell reported that the Trust's results placed it in the category of 'better than expected' together with six other trusts. No trusts were identified as 'much better than expected.' Ms Flavell felt that this was positive and hopefully would give a level of assurance to local communities. Ms Garvey congratulated the Trust on the positive outcome of the survey.	
013/22	**Ockenden Report Action Plan – Summary Update** Ms Hayley Flavell presented a high-level progress update on the Ockenden Report Action Plan. She explained the use of the Delivery and Progress Reverse RAG Rating and presented a slide showing all the Ockenden actions and their current delivery status. 43 actions have been implemented (83% overall) comprising 27 (52%) evidenced and assured	

	and 16 (31%) delivered but not yet evidenced. Nine actions (17%) are not yet delivered. Ms Flavell explained that of the nine actions not yet delivered, 4.90 related to training and ensuring senior anaesthetic staff participate in maternity incident investigations and confirmed that the team is on track to deliver this. The other eight outstanding actions are dependent on continuing to ensure progress with external partners. It was noted that the meeting of the Committee scheduled for march would review the action plan in detail and particularly the outstanding actions. In discussion, it was noted that with the publication of the final Ockenden Report the same structured approach would be taken to delivering any recommended actions. Dr McMahon observed that it had always been known that there would be a further Ockenden Report and she felt that the work and progress that the Trust had made since the publication of the first report would enable the Trust to build on and consolidate the work that had been undertaken to date. Ms. Garvey asked Hayley Flavell to comment on the IEA 2.4 (Immediate and Essential Action) that requires CQC inspections to include an assessment whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership (MVP). It was explained that the resolution of this action rests with the CQC. Ms. Sharon Fletcher confirmed there is a plan for all outstanding actions relating to the LMNS (Local Maternity & Neonatal System) – IEAs 1.1, 1.3 and 1.4, with a LMNS Programme Lead in post from December 2021. In relation to the action that the Trust needs to operate beyond a single provider LMNS, Ms. Fletcher confirmed that there is a memorandum of understanding in place, but there needs to be a final resolution regarding the content of the buddying arrangement.	
014/22	**Improving the Organisational Culture** The Committee heard from Ms. Rhia Boyode (Director of People & OD), Ms. Vicki Robinson (Interim People & OD Business Partner for Women's and Children's Services) and Ms. Claire Eagleton (Interim Matron for Acute Inpatient Services & Maternity Outpatients) regarding the range of work and initiatives that are being undertaken at corporate and directorate level to engage with staff and improve the organisational culture. Ms. Boyode explained the work that the Trust had been undertaking with NHSEI and Kings College London regarding a structured approach connected to the Trust's and national priorities – the Trust Culture dashboard and the NHS seven people promise initiative. She explained the five themes relating to compassion, learning and innovation, vision and values, goals and performance, and teamwork. This year there	

would also be an additional theme relating to health and wellbeing. Ms Boyode explained that the dashboard enabled the Trust to understand if improvements and progress was being made. a slide showing five key theme areas:

Ms. Vicki Robinson explained some of the initiatives that were taking place in the Women's and Children's Directorate, including a middle management leadership development programme, the establishment of maternity support workers on wards, B7 co-ordinators on wards, the provision of psychological support, and the introduction of "stay conversations".

Ms. Claire Eagleton gave a presentation on the Improvewell app. She explained that the team have secured 500 licenses for the app which means all staff in Maternity will be able to engage. It gives staff a voice and an ability to communicate. The app has four key features:

- Sentiment tracker (have you had a good day?)
- Idea hub
- Pulse surveys
- Push notifications

She explained that the team had worked with a Midwife from Royal Cornwall Hospital Trust who are already using the app. From her experience Improvewell Champions were identified in all key areas of the team. The app launched on 31st January 2022 and in two weeks over 116 people have downloaded the app. During those two weeks 23 ideas for improvement have been received. The Idea Hub allows staff members to put forward an idea for improvement, this idea can then be shared with others in the group and voted on to decide if the idea is a good one. Quick wins can be actioned immediately.

Ms. Eagleton explained one of the ideas for improvement already received and actioned was the suggestion of a white board in the theatre to be updated with the names of all staff members present. Another idea was the production of laminated QR codes displayed in rooms so that staff can take an iPad to the QR code, scan it and they will be taken to the appropriate part of the intranet.

In response to a question from Ms Garvey, Ms Eagleton confirmed that the app was not for use where people wished to raise concerns but a vehicle to enable staff to raise ideas.

Ms. Garvey asked Ms. Boyode to give an overview of the general mood amongst the staff. Ms Boyode commented that people are physically and mentally exhausted from the pandemic and obviously concerned about the publication of the final Ockenden report. She explained that she sensed that people needed some time to recover, rest and reflect. In this respect Ms Boyode reminded the meeting of the importance of the Clinical Psychology Hub as facility available to all staff.

Ms. Garvey asked Rhia Boyode if staff have to self-refer to the Clinical

	Psychology Hub. In response, Ms Boyode confirmed that it is a mixture of both, people can self-refer or be referred by managers. In support, Ms Flavell commented that the Clinical Psychology Hub was seen as a safe space and spoke about the huddles which happen twice a day. In response to a question about staffing levels in maternity services generally, Ms Flavell explained that she felt the team was in a much better position than last summer and particularly during the period earlier in the year when staff had been contacted by track and trace and were unable to work. However, now the Director of Midwifery is in post, along with three Matrons. The team are working on a 90/10 split (90% midwives, 10% maternity support). A recent Health Education England survey of learners has shown favourable results for SaTH as being a good place to learn. Ms Eagleton also confirmed there is ongoing improvement for Band 6 staff recruitment and that it is encouraging that the Trust is an organisation where people wish to come and work.	
015/22	**Governance and Assurance** Ms Kath Preece (Assistant Director of Nursing, Quality Governance), Ms. Liz Pearson (Quality Governance Lead, Women and Children's Division) and Mr Tom Baker (Deputy Director of Operations, Women & Children's Division) gave an update on the quality governance and assurance arrangements within the maternity services directorate. Mr Baker reminded the meeting that the Ockenden Report had specifically drawn attention to the need for the Trust to improve its quality governance arrangements – "*for the governance documentation considered so far for this report the review team have found inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes."* It was explained that 22 (made up of 15 Local Actions for Learning, and 7 Immediate and Essential Actions) of the actions in the Ockenden Report focus on quality governance and of these twelve have been delivered and assured, seven have been delivered but not yet evidenced, and three have not yet been delivered. The Committee heard specifically about the quality governance Ockenden Actions relating to the Quality Governance Team, incident investigation and learning processes. Improvements in the quality governance structure were reported with specific reference to LAFLs (Local Actions for Learning) 4.59 and 4.60, with both actions delivered but not evidenced. It was also explained that IEAs (Immediate and Essential Actions) 1.2 and 1.6 relating to the requirement for external clinical opinions following a neonatal death, neonatal brain injury and maternal death, and the requirement for maternity serious incidents to be reported to the Trust Board respectively, had been delivered and evidenced. IEA 1.1 requiring structured reporting mechanisms remains outstanding and requires the development of a standard operating procedure to demonstrate how it will report both internally and externally through the LMNS (Local Maternity and Neonatal System).	

	Ms. Preece explained the new quality governance structure to the meeting including a hierarchy chart showing line management structure and professional oversight lines. She outlined the key functions of the quality governance teams: • Divisional governance • Handling of complaints • Audit • Incident management (Datix) • Serious incidents • Divisional investigations • Learning from deaths • Clinical negligence claims Ms Preece also explained that in November 2021 the quality governance framework was implemented after liaising with other organisations like University Hospitals Birmingham and Sherwood Forest. Each division now has its own quality governance team. All posts within the Maternity, Women's and Children's Division are now full, in place and working well. Ms Kath Preece also explained the clinical incident management policy. Kath chairs a Trust-wide rapid review meeting every Thursday which looks at all incidents of moderate harm and above. On the same day a Review, Action, and Learning for Incident (RALI) group meets which is chaired by the Medical Director. From this meeting the Trust has 48 working hours to report the incident to the national reporting system. And there is a contractual obligation to give a 72-hour update for the serious incidents. Learning from incidents is the biggest focus for the team moving forward and the introduction of the new Patient Safety Incident Review Framework, with the plan to transition to the new framework from April 2022. Ms Garvey asked about the significance of multi-disciplinary incident teams. Ms. Preece commented that each profession looks at things in a different way, so it is important to get all views together. Dr John Jones added that the multi-disciplinary approach helps with regards to not missing things, it is a less fallible approach. Ms. Garvey then asked whether everybody felt safe to really say what they think in such meetings. In response Ms. Preece and Dr Hon felt that staff did feel able to speak up in such meetings. Dr McMahon asked whether during the incident management process leaders have the confidence to not seek blame, commenting that she felt it important to demonstrate that the objective is not to blame so that people feel safe coming forward. Jane Garvey invited the very recently appointed and in post Director of Midwifery, Ms. Annemarie Lawrence, to comment. Ms Lawrence explained that whilst she had only come into post yesterday, she was	

	encouraged and wished to ensure that there was an acceptance of a positive culture of escalation in a safe environment. Ms. Garvey commented that she felt openness to be the key; people should be willing to share and not be afraid to speak out. Ms. Lawrence added that compassion and visible leadership is key. She felt the MVP relationship was extremely important and the transparency that the ORAC meetings give to stakeholders. Ms Garvey wished her well in her new role.	
016/22	**Observations and comments from relevant stakeholders and groups representing service users:** No comments were received.	
017/22	**Discussion and reflection:** Mr Mike Wright confirmed the next meeting is on the 15th of March at which a review of all the actions from the first Ockenden Report will take place. All Board Directors will be invited to attend. ORAC members were asked to contact Mr Wright by 25th February if there were a topic they would like to hear more about at the March meeting. External stakeholders were also asked to come to the March meeting prepared to say something about what they have learned about the progress the Trust has made to date Dr McMahon added that it is recognised some people will prefer to submit their questions in writing and she assured people any emails received would be fully represented. She said that "critical friendliness" at the next meeting was important to allow the committee to close the first phase of Ockenden with confidence and open the second phase understanding what needs to be taken forward.	
018/22	**Date of next Ockenden Report Assurance Committee:** Tuesday 15th March 2022 at 14.30 via Teams Live Streamed meeting	
MEETING CLOSED		

Board of Directors Meeting in Public
February 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	/21			
Report	The Ockenden Report – Progress Report			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1, BAF 2 BAF 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 is requested to receive and review: • This report, the Ockenden Report Action Plan at **Appendix One.** There are no exception reports this month. • Decide if any further information, action and/or assurance is required			
Appendices	**Appendix One:** Ockenden Report Action Plan as at 3rd February 2022			
	 Hayley Flavell Director of Nursing 25 February 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 10 February 2022. 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 (MTP).

2.3 Since the last update to the Board of Directors, five further IEA's have been accepted by the Maternity Transformation Assurance Committee (MTAC) as 'Evidenced and Assured', as follows:

2.3.1 **IEA 1.6 ("All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.")** MTAC examined evidence of relevant investigation summaries and associated action plans, and suitably anonymised minutes from Trust Board of Directors' meetings, and took assurance from Local Maternity and Neonatal System (LMNS) colleagues at the meeting that this information is shared with them appropriately.

2.3.2 **IEA 4.2 ("Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.")** MTAC was satisfied with the evidence including a complex pregnancy Standard Operating Procedure document, and an audit of notes where women have complex pregnancies to ensure women have early specialist involvement and management plans developed by the clinical team in consultation with the woman. This audit will be repeated regularly to ensure ongoing compliance.

2.3.3 **IEA 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.")** MTAC was satisfied with the evidence including a Standard Operating Procedure (SOP), which is compliant with NICE guidance, detailing when and how such risk

[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.

assessments should be conducted, the Personalised Care and Support plan that is provided to women using the service, and an audit of case-notes checking that the intended place of birth is reviewed with the woman at each appointment.

2.3.4 **IEA 5.2 ("Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.")** MTAC was satisfied that the aforementioned audit confirmed that the intended place of birth is revisited at each appointment. They also accepted the guidelines on birth choices outwith guidance, as well as anonymised minutes from the Birth Options clinic showing supported, informed decision-making from service users.

2.3.5 **IEA 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.")** MTAC were satisfied with the resources provided to women via the Badgernet Electronic Patient Records system and associated checks and alerts to make sure the woman has been able to access and process them. They also took assurance from the promotion of the informative 'Baby Buddy' app as supported and championed by the MVP, and the questions within the Ockenden Case Notes audit relating to information provided to Service Users, which were proved to be compliant.

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

2.4.1 **LAFL 4.65 "The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.**" MTAC was satisfied with evidence of:

2.4.1.1 Compliance with the National Bereavement Care Pathway, following a review from Sands (The Stillbirth and Neonatal Death Society).

2.4.1.2 Job plans for the two in-post whole-time specialist Bereavement Care Midwives

2.4.1.3 Approved business case for an additional 90 hours of consultant time plus dedicated time for a consultant to provide bereavement care (supported by the LMNS). Once it has been decided who this lead consultant will be, it is likely that the Maternity Transformation Programme Group (MTPG) will recommend MTAC to accept this action as 'Evidenced and Assured'.

2.4.2 **LAFL 4.66 "The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway."** MTAC was satisfied with evidence of:

2.4.2.1 Bereavement care pathway guidelines has been updated; specifically, the most recent Foetal Loss Guidelines, which includes implementation of the National Bereavement Care Pathway.

2.4.2.2 Feedback from the recent Sands review and evidence that the Trust scores 90 out of a maximum possible of 120 points in compliance with the National Bereavement Care Pathway (this is classed as 'champion' level adoption).

2.4.2.3 Online training modules mandated for clinical staff (obstetric doctors, junior doctors, midwives and maternity support workers) – this has been loaded onto the Trust's new learning management system.

2.4.3 **LAFL 4.100 "There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit."** MTAC was satisfied with evidence of:

2.4.3.1 Confirmation that five Neonatal Consultants have already conducted these attachments at Neonatal Intensive Care Units in the region (University Hospital of the North Midlands and Birmingham Women and Children's). Detailed feedback on the learnings and benefits accrued from these attachments will be presented to the next MTAC by the Clinical Director for the Neonatal Unit.

2.4.3.2 Job plans showing that this two-week attachment has been factored in as an annual development opportunity for all consultants.

2.4.3.3 Plans for SaTH's Advanced Neonatal Nurse Practitioners to also undertake these attachments in the coming weeks and months.

2.5 In the same period, MTAC has accepted a further three LAFLs as 'Evidenced and Assured'.

2.5.1 **LAFL 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."** MTAC was satisfied with evidence of partial completion of the 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.

2.5.2 **LAFL 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."** MTAC was 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 3rd February 2022 is summarised in the following table. 27 actions (52%) are now at 'evidenced and assured' status with 16 (31%) at 'Delivered, Not Yet Evidenced' – an overall implementation rate of 83%.

Delivery Status							
	Total # recommendations	Not yet delivered		Delivered, Not Yet Evidenced		Evidenced and Assured	
		Jan 22	Current	Jan 22	Current	Jan 22	Current
LAFL	27	5	2	12	13	10	12
IEA	25	8	7	7	3	10	15
Total	52	13	9	19	16	20	27

3.2 Using the same approach, the **'Progress Status'** position of each action as at 3rd February 2022, is summarised in the following table:

Progress Status											
	Total # recs.	Not Started		On Track		At Risk		Off Track		**Completed**	
		Jan 22	Current	Jan 22	Current	Jan 22	Current	Jan 22	Current	Jan 22	Current
LAFL	27	0	0	16	14	0	0	1	1	10	12
IEA	25	2	2	13	7	0	1	0	0	10	15
Total	52	2	2	29	21	0	1	1	1	20	27

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 fall within the Trust to deliver, whilst other components are dependent upon national-level action being taken to establish specialist maternal medicine centres, which is out of the Trust's control.

3.3.2 The exception report for this action was provided at the October meeting, but no revised deadline has yet been agreed. The action was reviewed again at the February 2022 MTAC meeting, but a decision on revised delivery dates postponed to the March meeting as the status of the establishment of the regional Maternal Medicine Specialist Centre is likely to be clearer by this point.

3.4 **IEA 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**"). This is 'at risk' of missing its delivery deadline (28 February 2022). Though the action is 75% complete, there remains a requirement to publish a formal SOP detailing how the Trust reports internally and externally via the LMNS. A co-produced document has been prepared and will be shared at the next MTPG and, if ratified, with the next MTAC meeting.

3.5 There are two Immediate and Essential Actions that are not yet delivered/not started. Again, these remain unchanged. Much work has been done on both, and the progress status will be changed from 'not started' once a proposed delivery and evidencing date is agreed at the next MTAC meeting. The actions are:

3.5.1. **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;

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

The LMNS has already shared information with the MTP group evidencing delivery of the first action and collaborative progress on the second; full details will be shared with MTAC at its March meeting for further discussion, and reported to the Board of Directors in due course.

3.6 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, this plan remains on track for its latest agreed final delivery date of August 2022.

4.0 Ockenden Report Assurance Committee (ORAC)

4.1 The eighth Ockenden Report Assurance Committee took place on 15 February 2022 with a focus on People and Culture and Quality Governance.

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

DATE	TOPIC
Tuesday 15th March 2022 – 1430-1700 hrs	Full review of implementation and embedding of the actions of the first Ockenden Report

5.0 Summary

5.1 Good progress continues to be made against the required actions from the first Ockenden Report (2020), with 43 of the 52 actions (83%) having been implemented; of these, 27 (52% of the total 52 actions) have been 'Evidenced and Assured' and the remaining 16 (31% of the total 52 actions) having been 'Delivered, Not yet Evidenced'. MTAC will receive the results of the second Ockenden Report Case Notes Audit at their March meeting, based on which several more actions are likely to be accepted as 'Evidenced and Assured'.

5.2 It should be noted that the eight of the nine actions still at red ('Not Yet Delivered') status are dependent on external factors such as the establishment of the Maternal Medicine Specialist Centres and the national implementation of the independent senior advocate roles. This means that the Trust has delivered 98% of the actions it is responsible for leading on.

5.3 The Ockenden Report Action Plan from the first report has its final completion milestone due in August 2022, as agreed with the Maternity Transformation Assurance Committee and as 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 next Month (March 2022).

6.0 Action required of the Board of Directors

6.1 The Board of Directors is requested to receive and review:

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

Hayley Flavell
Executive Director of Nursing

March 2022

Appendix One: Ockenden Report Action Plan at 3 February 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.

APPENDIX ONE - OCKENDEN REPORT ACTION PLAN (as at 3 February 2022)

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.60	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

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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
4.64	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	Evidenced and Assured	Completed	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. MTAC agreed on 03/02/22 for this action to move to 'evidenced and assured' based on the evidence provided (updated, enhanced and ratified guidelines; ongoing compliance of guidelines audited, and 4 hourly reviews by medical staff)	22/04/21	28/02/22	03/02/22	Hayley Flavell	Shirley Jones	SaTH NHS SharePoint
4.65	The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.	Y	10/12/20	31/07/21	Delivered, Not Yet Evidenced	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. MTAC agreed on 03/02/2022 that the evidence provided (adoption of the National Bereavement Care Pathway, job plans for dedicated bereavement midwives and obsterician, along with the approved business case for an additional 90 hrs of consultant time plus SPA time for delivery of bereavement care) was sufficient for the action to move to 'delivered, not yet evidenced'.	03/02/22	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
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	28/02/22	Delivered, Not Yet Evidenced	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. MTAC agreed on 03/02/22 for this action to move to 'delivered, not yet evidenced' based on evidence provided (bereavement care pathway guidelines updated, SANDS review received and actions added to action plan; NBCP self-assessment conducted with 90/120 'champion' score, plus mantatory NBCP training being carried out by clinical staff).	03/02/22	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.

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	Evidenced and Assured	Completed	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. MTAC agreed on 03/02/22 for this action to move to 'evidenced and assured', as the evidence described above was met (escalation policy SOP in place and updated, CNST safety action 4 report and Ockenden casenotes audit review of escalation policy)	22/04/21	28/02/22	03/02/22	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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	Evidenced and Assured	Recommendation is in place; evidence proving this has been approved by executive and signed off by committee.

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.74	There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.	Y	10/12/20	31/03/21	Delivered, Not Yet Evidenced	On Track	Complex antenatal and postnatal inpatients are identified at the morning and evening Delivery Suite handovers 7 days a week. This information is recorded on the handover sheets. The on call consultant attends the antenatal ward round daily to conduct a ward round along with the Tier 2 doctor. They also attend the postnatal ward to review any women identified as complex. This will be evidenced by an attendance audit and through auditing the information on the handover sheets. 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

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

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

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

LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date (action in place)	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Lead Executive	Accountable Person	Location of Evidence
4.87	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	Vicki Robinson & Claire Eagleton	

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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	Delivered, Not Yet Evidenced	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. MTAC agreed on 03/02/22 for this action to move to 'delivered, not yet evidenced' based on the job plans devised to enable neonatal consultants and ANNPs regular observational attachments at NICUs and the honoury HR contracts in place with BWH and UHNM.	03/02/22	28/02/22		Hayley Flavell	Vicki Robinson & Claire Eagleton	SaTH NHS SharePoint

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