Appendix 3: Detailed Final Ockenden Action Plan – Created May 2022

Key -

With regional or national team to address	Work ongoing	Completed

Recommendation	Action	Lead	Due date	Update
• **Immediate and Essential Action 1: WORKFORCE PLANNING AND SUSTAINABILITY** • The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented • The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe	Request made to Regional Chief Midwifery Officer as require actions to be completed by regional and national groups	Director of Nursing and Midwifery,	**April 2022**	**Request made in April 2022, no update received as of 6.6.22**

Recommendation	Action	Lead	Due date	Update
maternity and neonatal care across England. • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements. • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.				

Recommendation	Action	Lead	Due date	Update
• All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce. • The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.				

Recommendation	Action	Lead	Due date	Update
Immediate and Essential Action 1: WORKFORCE PLANNING AND SUSTAINABILITY Training • All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this • All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical	Review current NQM workforce to understand how many staff are due to rotate to community within 12 months of qualification and amend accordingly.	Rotation Leads across MCS	**Completed**	**Closed**
	Amend preceptorship package to ensure that NQM do not receive a rotation into community	Education Team	**Completed**	**Closed**
	Gap Analysis of all leadership and management roles - Midwifery	DHoM ORC, supported by HoM	**August 2022**	**Ongoing**
	Gap Analysis of all leadership and management roles – Obstetrics	CHoD	**August 2022**	**Ongoing**
	Develop succession planning Strategy and SOP for midwifery	DHoM ORC, supported by HoM	**September 2022**	**Ongoing**
	Develop succession planning Strategy for Obstetrics	CHoD	**September 2022**	**Ongoing**

Recommendation	Action	Lead	Due date	Update
practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife. • All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.				
Immediate and essential action 2: Safe Staffing.	Review and risk assess current MCoC teams	Consultant Midwife and Associate Head of Midwifery	**Completed**	**Closed**

Recommendation	Action	Lead	Due date	Update
• All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain. • The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction • The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required	Update MCoC Action plan in line with amends from risk assessment	Consultant Midwife and Associate Head of Midwifery	**June 2022**	**Amendments required due to new guidance released 6th May 2022. Paper submitted to SM QSC for 9th June and onward reporting to Trust Board of Directors**
	Submit review and updated Action plan to SM QSC, Trust Board and GMEC LMS	Consultant Midwife and Associate Head of Midwifery	**June 2022**	
	Full review of obstetric training needs analysis which includes maternity specific training to be captured within job plan	CHoD	**July 2022**	**ongoing**
	SOP to be developed regarding use of matron, ward manager and LW Coordinator handbook	Deputy Heads of Midwifery	**July 2022**	**ongoing**

Recommendation	Action	Lead	Due date	Update
for generic trust mandatory training and reviewed as training requirements change • Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles				
Immediate and essential action 3: Escalation and Accountability • All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals	Amend bleep holder policy to clearly reflect role and ongoing escalation process	Inpatient/labour Ward site Matron	**Aug 2022**	**Bleep holder guideline in final stages before ratification.**
	Create SOP for Bleep holder regarding process of activating a deflect across SM MCS maternity sites	Head of Midwifery North Manchester	**June 2022**	**Ongoing**
Immediate and essential action 5: Clinical Governance Incident Investigation and complaints	SOP to be created	Divisional Governance Lead Obstetrician and Lead Midwife for Governance	**Aug 2022**	**Ongoing**

Recommendation	Action	Lead	Due date	Update
• Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred. • All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Discuss with SM MCS complaint Chair regarding how this can be incorporated in line with MFT complaints process	Associate Head of Midwifery	**June 2022**	**ongoing**
Immediate and essential action 6: Learning from Maternal Deaths • NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that a joint review panel is provided in any case of a maternal death. • This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek	Request made to Regional Chief Midwifery Officer as require actions to be completed by regional and national groups	Director of Nursing and Midwifery,	**April 2022**	**Request made in April 2022, no update received as of 6.6.22**

Recommendation	Action	Lead	Due date	Update
external clinical expert opinion where required.				
Immediate and essential action 7: MDT Training • All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS. • Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	Review current human factor training and submit to LMS for approval	Lead Midwife for Education GMEC LMS	**July 2022**	**Training plan submitted to GMEC LMS. Awaiting LMS response regarding approval of human factors training**
	Review maternity workforce to identify current gap	Matrons	**Completed**	**Closed**
	Review Obstetric workforce to identify current gap	Lead Obs	**Completed**	**Closed**
	Allocate all outstanding on nearest available training	Education team/CTG champions	**Completed**	**Closed**

Recommendation	Action	Lead	Due date	Update
	Undertake gap analysis review on those requiring training over next 3 months ensuring all allocated to prevent any non-compliance	Education team/CTG champions	**June 2022**	**Ongoing. Staff identified and training sessions now booked to support continued training compliance.**
	Communicate with all staff the importance of remaining compliance with CTG and emergency skills training.	CHoD and HoM	**Completed**	**Closed**
Immediate and essential action 9: Preterm Birth • Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered • Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal	Capture compliance of discussion and documentation in maternity record within PreCEpT audit	Precept champions	**July 2022**	

Recommendation	Action	Lead	Due date	Update
survival and are aware of the risks of possible associated disability.				
Immediate and essential action 10: Labour and Birth It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Await risk assessment to be created by national team			**Request made for update of progress in April 2022, no update received as of 19.5.22**
	Review current information provided by Community Midwives	Consultant Midwife	**July 2022**	**ongoing**
	Link with NWAS to confirm current transfer times for birth outside of hospital	Consultant Midwife	**July 2022**	**ongoing**
Immediate and essential action 11: Obstetric anaesthesia • Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to	Await resources to be created and made available nationally			**Request made for update of progress in April 2022, no update received as of 19.5.22**
	Request CSS response for compliance across all 3 maternity sites.	Associate Head of Midwifery	**June 2022**	**Update expected by 10.6.22**

Recommendation	Action	Lead	Due date	Update
maximise national engagement and compliance • Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia • Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.				

Recommendation	Action	Lead	Due date	Update
• All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC • Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.				

Recommendation	Action	Lead	Due date	Update
• The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report				
Safety Action 12 - Postnatal Care • All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward. • Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum. • Postnatal readmissions must be seen within 14 hours of	Review consultant capacity to support postnatal activity on all 3 sites	Clinical Head of Division	**July 2022**	**ongoing**
	Amend postnatal guideline to support change in practice for readmissions	Lead Obstetrician for inpatients	**Sept 2022**	**ongoing**

Recommendation	Action	Lead	Due date	Update
readmission or urgently if necessary.				
Safety Action 12 - Neonatal Care • Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation. • Each network must report to commissioners annually what measures are in place to	**NW ODN confirmed compliance with this action**	North West ODN	**Completed**	**Closed.** **Update from NW ODN 8.6.22 has confirmed compliance with the all metrics within this action.**

Recommendation	Action	Lead	Due date	Update
prevent units from working in isolation. • Implement recommendation from Neonatal Critical Care Review (2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families				
• Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Recruit to junior medical vacancy on Wythenshawe site Consider additional work required to increase in consultant workforce to be compliant	Newborn Services CHoD and DD	**Sept 2022**	**ongoing**
Safety Action 15 – Supporting families	Work with Mental Health team to ensure robust monitoring and referral pathways	Consultant Midwife and Mental Health Team	**Dec 2022**	**ongoing**
• There must be robust mechanisms for the identification of psychological	Review capacity of current specialist maternity counsellor and link with SLA	Head of Midwifery, North Manchester	**October 2022**	**ongoing**

Recommendation	Action	Lead	Due date	Update
distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences**.**				