Appendix 1 Progress since June 22 to achieve compliance with Immediate and Essential Actions of the final Ockenden Report.

This table only includes actions which were open in June 22 when SMMCS last reported to the Health Scrutiny Committee. Actions which had already been closed by June 22 are not included.

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 maternity and neonatal care across England. • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels,	Request made to Regional Chief Midwifery Officer as require actions to be completed by regional and national groups	Director of Nursing and Midwifery,	**TBC**	**Meeting held with Deputy Regional Chief Midwifery Officer, no updates at this time. To await further information in the following months.**

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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. • 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				

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shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.				
Immediate and essential action 5: Clinical Governance Incident Investigation and complaints • 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.	Amend divisional governance report to demonstrate any changes to practice following SI are implemented within allotted timescale.	Divisional Governance Lead Obstetrician and Lead Midwife for Governance	**Completed**	**Closed**
	Work required from governance team to link with group regarding service user review of complaint process		**Work required from Group – Deadline 2023**	**Maternity Voices Partnership (MVP) will be invited to complaint user participation group once set up.**
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	Request made to Regional Chief Midwifery Officer as require actions to be completed by regional and national groups	Director of Nursing and Midwifery,	**TBC**	**No deadline provided. Awaiting regional update in due course**

Recommendation	Action	Lead	Due date	Update
seek 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	**Completed**	**Closed**
	Await work nationally and regionally regarding review of human Factors training	GMEC LMS	**TBC**	**LMNS confirmed that they are awaiting national guidance on human factors training and will update in due course.**
	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**
	Undertake gap analysis review on those requiring training over next 3	Education team/CTG champions	**Completed**	**Closed**

Recommendation	Action	Lead	Due date	Update
	months ensuring all allocated to prevent any non-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 survival and are aware of the risks of possible associated disability.	Capture compliance of discussion and documentation in maternity record within PreCEpT audit	J Myers	**October 2022 Extended to July 2023**	**Will be captured with an electronic proforma within Hive. Awaiting DQ issues to be resolved before template test in system.**
Immediate and essential action 11: Obstetric anaesthesia	Request CSS response for compliance across all 3 maternity sites.	Associate Head of Midwifery	**completed**	**Report received 10.6.22**
• 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 maximise national engagement and compliance	Await resources to be created and made available nationally	CSS	**TBC**	**Awaiting update from Royal College of Anaesthetists**

Recommendation	Action	Lead	Due date	Update
• 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	Ensure all pathways in place ahead of the introduction of HIVE to include a postnatal database detailing patients being followed up. This will significantly upgrade the ability to track patients and outcomes.	CSS Business Case for ORC has been written and waiting approval within CSS before comes to obstetrics. Extra clinic. Accommodating existing	**Oct 2022 (extended to Q4 22/23)**	**Partially compliant. Business case and recruitment in progress to provide substantive clinic at Oxford Road and North Manchester. Currently women are being accommodated on existing clinics through local arrangements. Wythenshawe have a dedicated postnatal clinic in place.**
• 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.	Develop SOP to detail role and responsibilities across anaesthetic service. Once created this will support HIVE and he ability to track patients and outcomes.	CSS Currently undertaken on IP follow up. A more robust approach when create a targeted questions in the PN aspect. Signpost to follow up services. Physician Builder Course July 23.	**Q4 22/23**	**Standardised postnatal script is planned to be built into Hive. Currently documentation is input into the existing follow up section on Hive. Timescale to complete script October 23.**
• All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as	Integrate documentation into HIVE and provide harmonised approach across 3 sites.	CSS	**Complete**	**Closed**

Recommendation	Action	Lead	Due date	Update
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.	compliant across all 3 sites -work ongoing to strengthen process including harmonisation of SOPs.	CSS	**End of August 2023**	**Full complement of staff in place. Roles and responsibilities outlined by Royal College of Anaesthetists. Additional SOP being developed by North Manchester, to reflect OOH provision for a 2nd theatre.**
• 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.	Harmonisation across 3 maternity sites	CSS	**Closed**	**Compliant with CNST and support training achievement of training compliance.**
• The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	Compliant but in addition - Awaiting competency assessment from RCoA	CSS	**Closed**	**Compliant**
• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report	Compliant		**Closed**	**Closed**