NHS
The Shrewsbury and Telford Hospital
NHS Trust

Ockenden Review Assurance Committee (ORAC)

Responses to Questions from Stakeholders:

Dr Anthea Wilson, Powys Community Health Council

Presenters:

Mrs Annemarie Lawrence – Director of Midwifery, SaTH

Dr Mei-See Hon – Clinical Director for Obstetrics, SaTH

Mr Martyn Underwood – Women & Children's Divisional Medical Director, SaTH

Mr Tom Baker – Deputy Director for Operations, Women's and Children's, SaTH

Date: 15.03.2022

1 - How confident are you (Trust and maternity representatives) that the improvements made as a result of the Ockenden report can be maintained? After all, failings in care occur repeatedly throughout the NHS and it can seem as though lessons learned are readily forgotten.

Presenter: Mr Martyn Underwood

Q1 Answer

The Shrewsbury and Telford Hospital NHS Trust

1. Listening to women and families
2. Rolling Ockenden case notes audit tool
3. Strong partnership with Maternity Voices Partnership (MVP)/ Local Maternity and Neonatal Systems (LMNS)
4. Maintaining dedicated project management team
5. Ongoing training (PRactical Obstetric Multi-Professional Training (PROMPT))
6. Continuous improvement & embedding of lessons learnt
7. Dedicated and ongoing funding and people to do the work
8. Embedding new clinical governance team/ structure
9. Implementation of NHSE/I Patient Safety Incident Response Framework (PSIRF)
10. Staff buy in (E.g., ImproveWell, User Experience (UX) system)
11. Evolving maternity and neonatal dashboards
12. Externally validated feedback and peer review
13. Care Quality Commission (CQC) Inspections
14. Use of reverse Red, Amber, Green (RAG) rating, robust governance processes in place and evidence storing (Monday.com) (more information on next slides)

Use of Reverse RAG Rating system

The Shrewsbury and Telford Hospital NHS Trust

Delivery Status

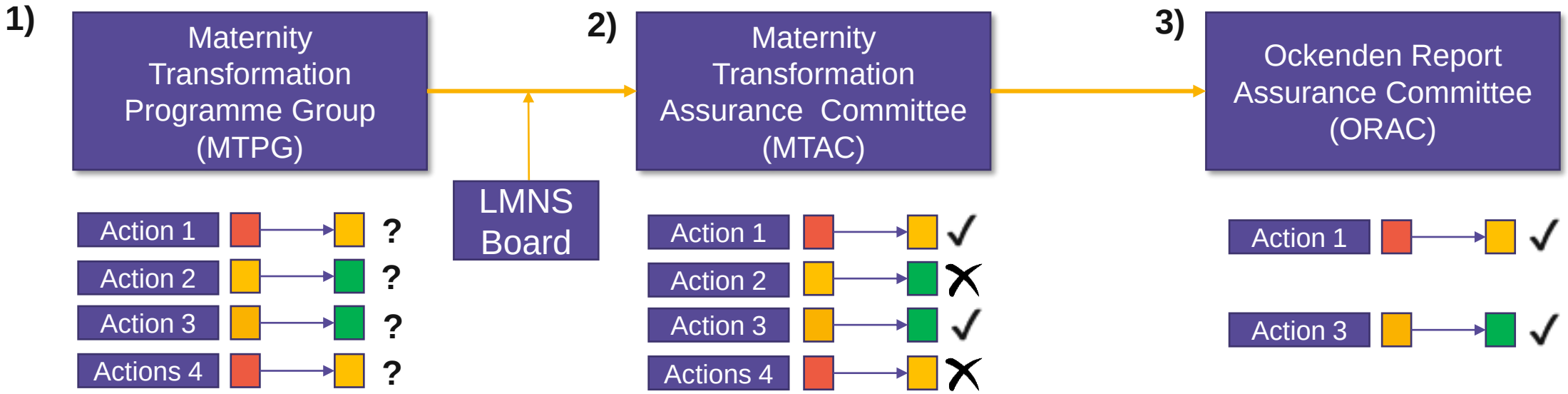
Colour	Status	Description
	Not yet Delivered	Action is not yet in place, there are outstanding tasks to deliver.
	Delivered, not yet Evidenced	Action is in place with all tasks completed, but has not yet been assured/evidenced as delivering the required improvements.
	Evidenced and Assured	Action is in place; with assurance/evidence that the action has been/continued to be addressed.

Progress Status

Colour	Status	Description
	Not Started	Work on the tasks required to deliver this action has not yet started.
	Off Track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At Risk	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where possible.
	On Track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that the action is being delivered and sustained.

Assurance and Governance process

The Shrewsbury and Telford Hospital NHS Trust



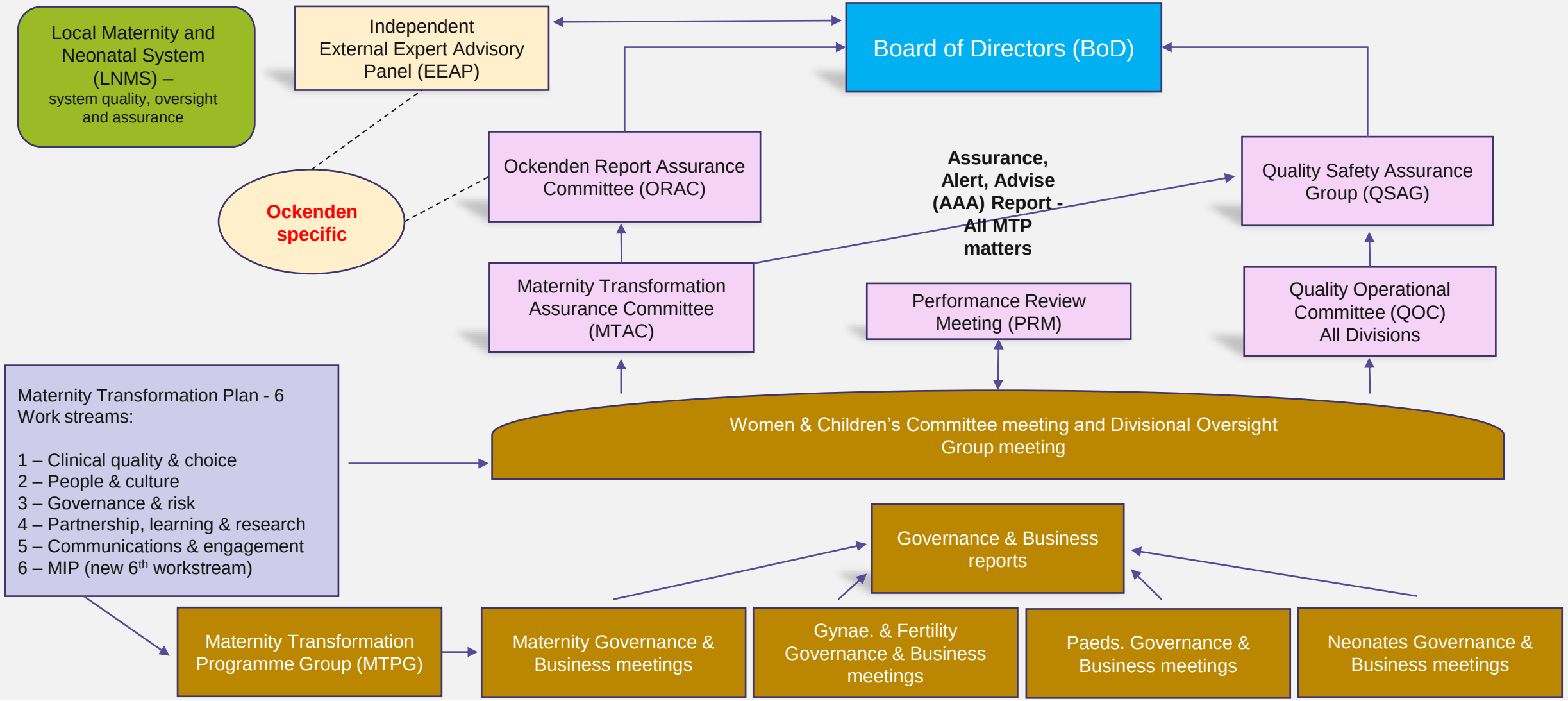
- Raise, manage and escalate risks & issues
- Oversee finance
- Document lessons learnt & best practice
- Review & propose status changes

- Review completion evidence
- Accept/Reject status change proposals
- Review and agree exception reports/change requests
- Act upon escalated risks & issues
- Provide forum for stakeholder input & discussion
- Agree key assurance topics for discussion at ORAC

- To provide assurance of Ockenden completion
- Sub committee of Board of Directors
- Independent co-chair
- Stakeholder involvement
- Live-streamed to public

Maternity Governance & Assurance Structure

The Shrewsbury and Telford Hospital NHS Trust



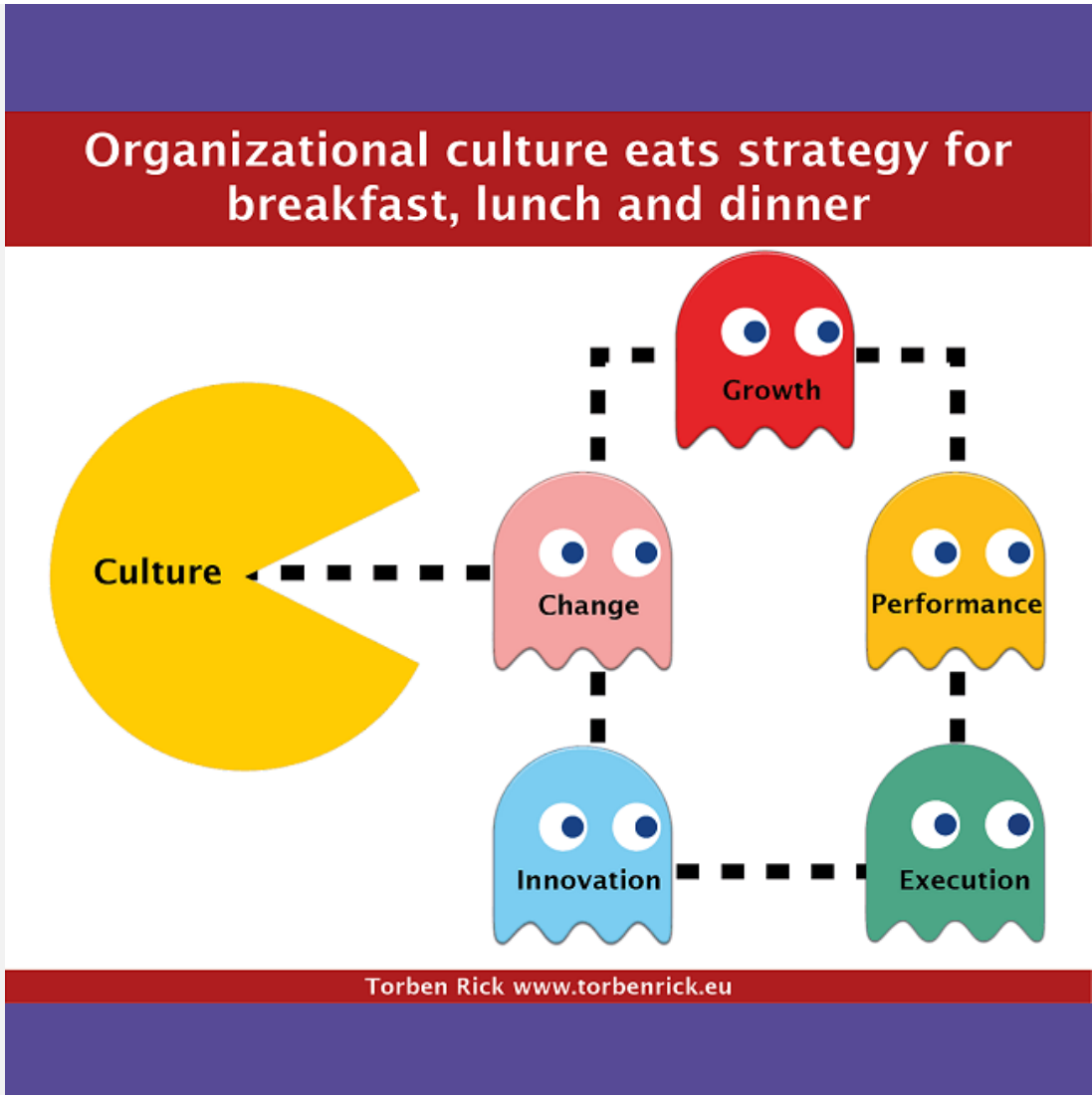
Q2 - Is there any further cultural change required to enable service users to become equal partners in care?

Presenter: Mrs Annemarie Lawrence

Q2 Answer

Cultural change → fluid → continuous improvement

1. MTP as foundation for improvement
2. Leading by example
3. Doing the right thing even when no one is looking
4. Calling out poor behaviour
5. Ethos of leadership within Trust
6. A culture of escalation at all times
7. Psychological safety
8. Transparency and duty of candour
9. Listening to service users and staff
10. Co-production of services (e.g., to continue to involve MVP in recruitment processes)



Q3 - To an extent, risk is subject to individual interpretation. How have the measures implemented as a result of the Ockenden Report helped to bring a team approach to the interpretation of risk, and have any additional necessary measures been identified during the improvement process?

Presenter: Mr Tom Baker

Q3 Answer

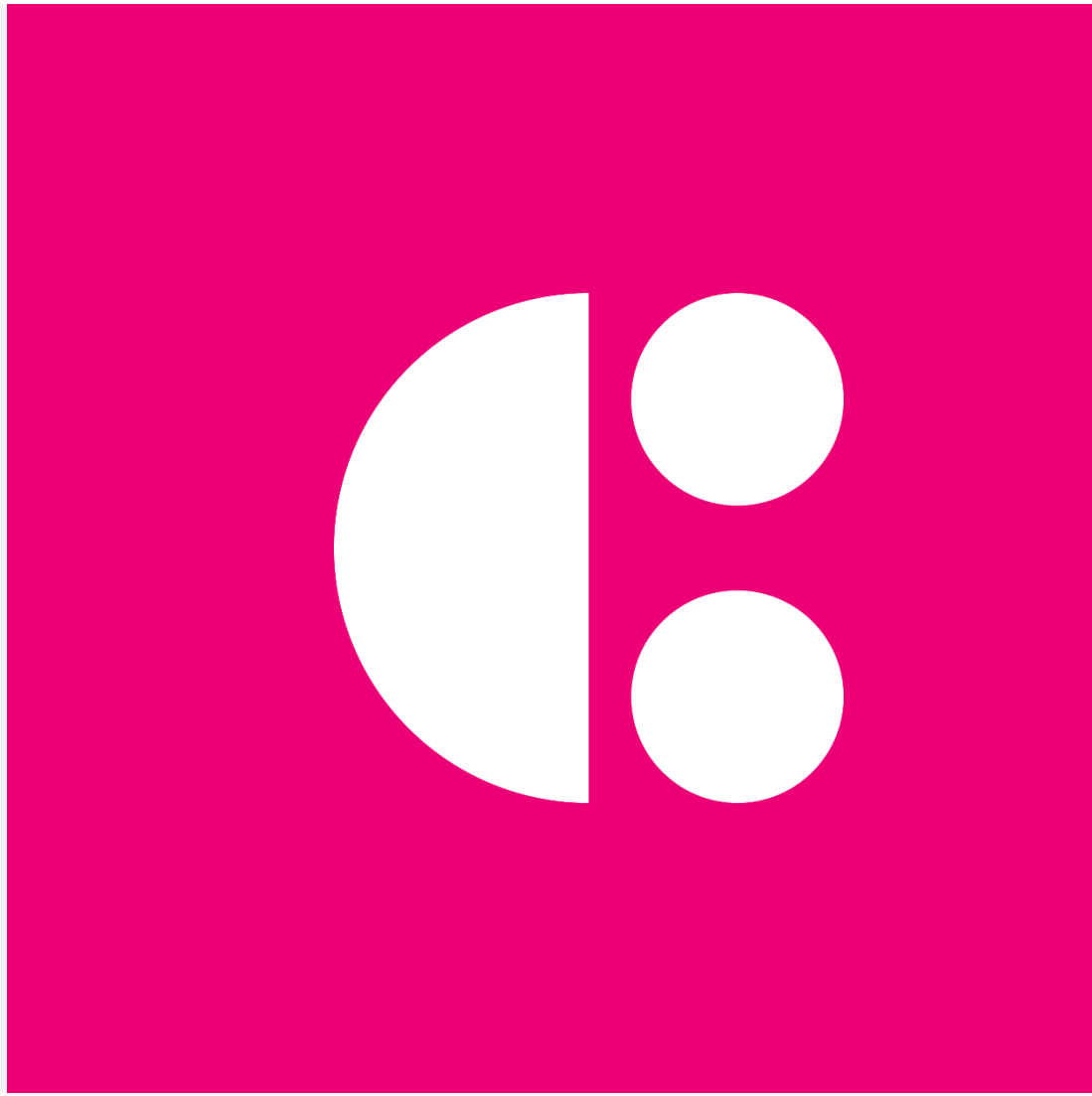
1. New governance team structure in place (we identified the need to strengthen leadership within the team)
2. Robust governance processes being followed
3. Stability within the team enabling us to look back at historic cases and also look forwards to maintaining safety with the current day-to-day incidents and escalation to investigations
4. Audit midwife recruited
5. Clear lines of accountability
6. PSIRF: Quality governance
7. External reviews conducted

Q4 -To what extent do the risk assessments carried out at each appointment contribute to the 'whole picture'? Do the information systems allow clinicians to easily view past assessments and take them into account?

Dr Mei-See Hon

Q4 Answer

1. Rolling Ockenden Case notes audit
2. Birth Options clinic
3. Multidisciplinary Team personalised care meeting
4. Continuous risk assessments
5. Positive feedback example (covered in slide 38)

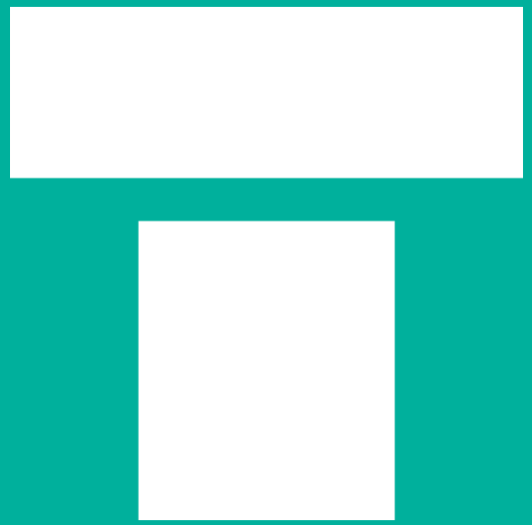


Q5 - Does the emphasis on training and working together go far enough to support truly collaborative team working? Have you identified further needs or measures that would help?

Mr Martyn Underwood

Q5 Answer

1. PROMPT
2. Skills drills
3. Multidisciplinary Team (MDT) governance feedback meetings
4. MDT ward rounds
5. New Learning Management System (LMS) in place
6. Visiting other units to enhance learning
7. Further measure identified:
    - To create a learning and development meeting to signal extra training required, identify outliers or identify colleagues who may require extra support.
    - Sharing lessons learnt with region/ special interest group.



Feedback received from Safety Oversight Assurance Group (SOAG)

The Shrewsbury and Telford Hospital NHS Trust

Really good to see that you have secured the substantive senior leadership in maternity services. That looks a really robust governance and assurance approach - very impressive. Also - we should acknowledge the very good staffing levels - midwifery achieving Birthrate plus and Obstetricians on labour suite 24/7.

Really impressive presentation and progress made- great to hear. Some fantastic progress on maternity and other issues as evidenced by removal of conditions.

It must feel good for the staff to see all their hard work across such a wide range of service recognised by the CQC in removing so many of the original S31 conditions. Congratulations.

These positive comments are reflected in comments we have previously had from our medical students and postgraduate medical learners too.

The level of clinical and operational engagement comes through really strongly.

Any more questions?

Ockenden Review Assurance Committee (ORAC)

Progress on the implementation of the actions arising from the first Ockenden Report (2020)

Presenters:

Mrs Annemarie Lawrence – Director of Midwifery, SaTH

Dr Mei-See Hon – Clinical Director for Obstetrics, SaTH

Mr Martyn Underwood – Women & Children's Divisional Medical Director, SaTH

Dr Patricia Cowley - Clinical Director for Neonates, SaTH

Date: 15.03.2022

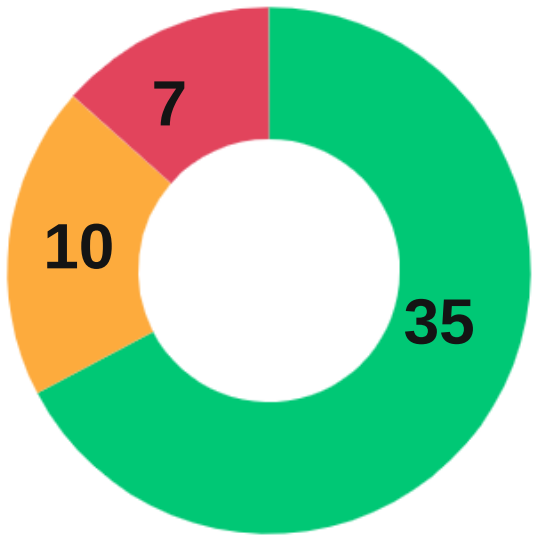
We acknowledge the receipt of the actions from the Independent Maternity Review (IMR) in good faith and the need to implement them in order to improve the quality of care provided

52 Actions Specific to SaTH - 27 LAFLs For all Trusts - 7 IEAs (comprising 25 sub-actions)

Mr Martyn Underwood

Ockenden Update: Delivery Status

The Shrewsbury and Telford Hospital NHS Trust



LAFL 4.54	LAFL 4.55	LAFL 4.56	LAFL 4.57	LAFL 4.58	LAFL 4.59	LAFL 4.60	LAFL 4.61	LAFL 4.62	LAFL 4.63	LAFL 4.64	LAFL 4.65	LAFL 4.66
LAFL 4.72	LAFL 4.73	LAFL 4.74	LAFL 4.85	LAFL 4.86	LAFL 4.87	LAFL 4.88	LAFL 4.89	LAFL 4.90	LAFL 4.91	LAFL 4.97	LAFL 4.98	LAFL 4.99
LAFL 4.100	IEA 1.1	IEA 1.2	IEA 1.3	IEA 1.4	IEA 1.5	IEA 1.6	IEA 2.1	IEA 2.2	IEA 2.3	IEA 2.4	IEA 3.1	IEA 3.2
IEA 3.3	IEA 4.1	IEA 4.2	IEA 4.3	IEA 4.4	IEA 5.1	IEA 5.2	IEA 6.1	IEA 6.2	IEA 6.3	IEA 7.1	IEA 7.2	IEA 7.3

- Evidenced & Assured
- Delivered, Not Yet Evidenced
- Not Yet Delivered

45 Actions Implemented (86% overall), comprising:

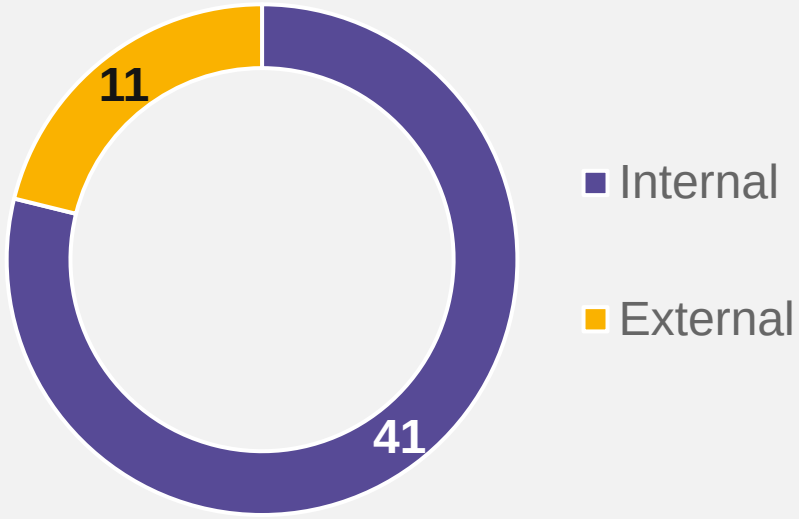
- 35 (67%) Evidenced & Assured
- 10 (19%) Delivered, Not Yet Evidenced

7 (14%) Actions ‘not yet delivered’

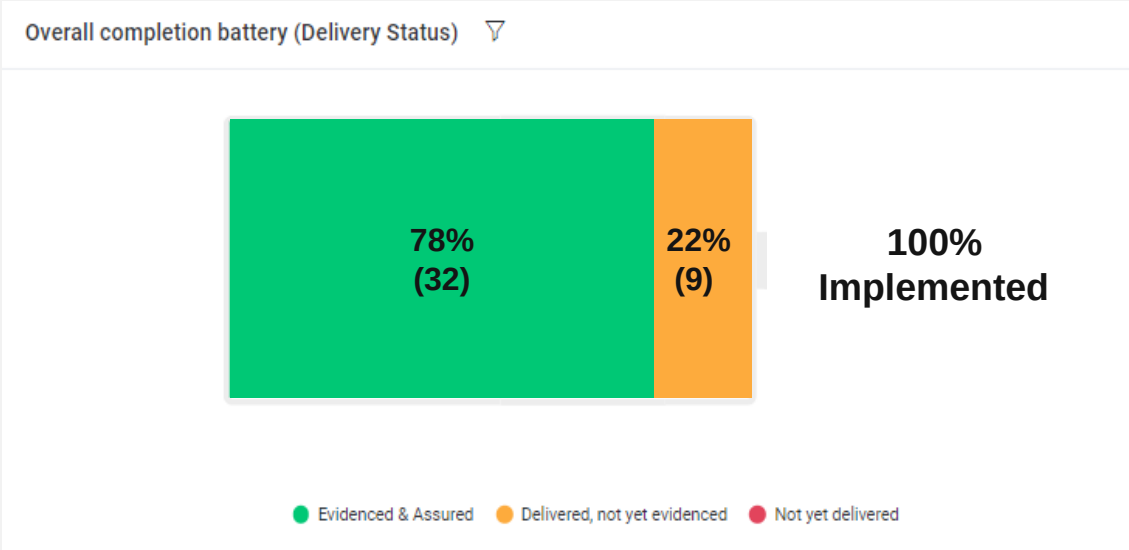
Internal Actions – Completion Rate

The Shrewsbury and Telford Hospital NHS Trust

Internal vs. External Actions



Completion battery for Internal Actions



Of the 52 Actions:

- 41 are Internal to SaTH (79%)
- 11 are External to SaTH (21%)

Of the 41 Internal actions:

- 32 are ‘Evidenced and Assured’ (78%)
- 9 are ‘Delivered not yet Evidenced’ (22%)

‘Not Yet Delivered’ (Red) Actions

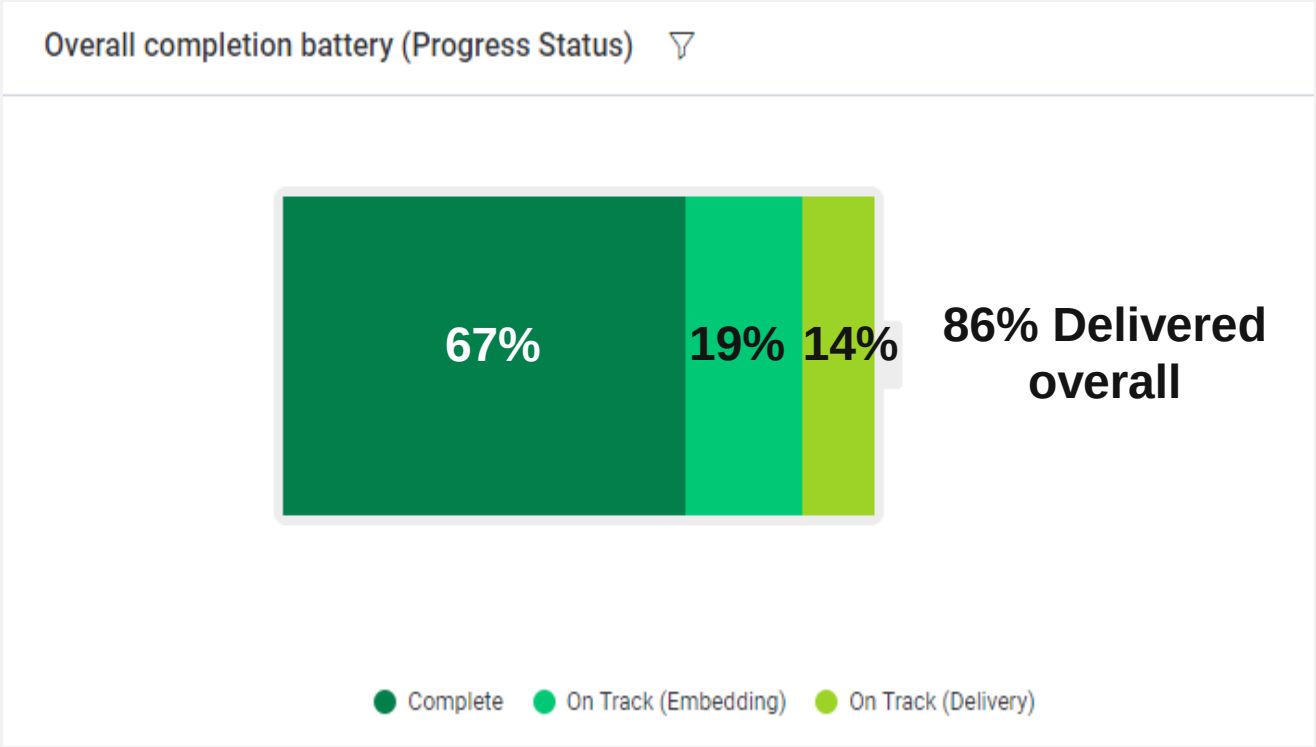
The Shrewsbury and Telford Hospital NHS Trust

Action	Dependency	Reasons	Due date
LAFL 4.73	External	National/ regional dependency on the establishment of the Maternal Medicine Specialist Centres (go live date: April-22)	Oct-22
IEA 1.3	External	The action relates to the LMNS having greater accountability and responsibility to ensure safe services. LMNS colleagues are working to provide a due date and list of evidence requirements before this action can move forward.	Apr-22
IEA 1.4	External	The action states that ‘an LMNS cannot function as one maternity service only’. LMNS colleagues are working to provide a due date and list of evidence requirements before this action can move forward.	Apr-22
IEA 2.1	External	This action relates to Trusts creating an independent senior advocate role which reports to both the Trust and the LMNS Boards. These roles are being developed, defined and recruited nationally. It is understood that this process in underway.	TBC
IEA 2.2	External	The action states that the advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Once in post, methodology for this is to be developed. Action linked to 2.1.	TBC
IEA 2.4	External	This action indicates that CQC inspections must include an assessment of whether womens’ voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership (MVP). The rests with the CQC to deliver.	Mar-22
IEA 4.3	External	National/ regional dependency on the establishment of the Maternal Medicine Specialist Centres (go live date: April-22)	Oct-22

Actions - Progress

The Shrewsbury and Telford Hospital NHS Trust

- This battery diagram shows the progress with the delivery of all 52 actions for SATH
- Those in **dark green** are fully delivered and are evidenced as working/embedded as they should be (67%)
- The **mid-green** represents actions that have been delivered but we are awaiting evidence that they are working/embedded (19%)
- The **light green** actions are all on track to be delivered but have not yet been delivered (14%).
- Of these 14%, all are on track but have external dependencies, as follows:
  - 1 x action for the CQC to implement
  - 2 relate to the development of regional maternal medicine specialist centres
  - 2 relate to the introduction on Independent Maternity Advocates (to be funded and managed nationally)
  - 2 relate to the Trust being part of a Single Local Maternity and Neonatal System (LNMS)



Regional benchmarking of 12 clinical IEA actions

KEY
Compliant
Partially Compliant

7 Ockenden IEAs (including 12 Clinical Priorities)																			ST&W SaTH		TOTAL	
1) Enhanced Safety																						
A plan to implement the Perinatal Clinical Quality Surveillance Model																					17	4
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB																					20	1
2) Listening to Women and their Families																						
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services																					18	3
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion																					19	2
3) Staff Training and working together																						
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week																					15	6
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.																					19	2
Confirmation that funding allocated for maternity staff training is ringfenced																					18	3
4) Managing complex pregnancy																						
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place																					19	2
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres																					16	5
5) Risk Assessment throughout pregnancy																						
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance																					13	8
6) Monitoring Fetal Wellbeing																						
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.																					13	8
7) Informed Consent																						
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.																					10	11

(Source; NHSEI, 2022)

Although we have implemented 86% of the overall IMR actions, we acknowledge that there is still much more to be done to ensure the best possible maternity standards and care

Summary of Achievements - Local Actions For Learning (LAFLs)

Dr Mei-See Hon and Mr Martyn Underwood

Theme 1: Maternity Care

- ✓ Multi-disciplinary twice-daily ward rounds on Delivery Suite.
- ✓ Two fetal monitoring lead midwives and one lead consultant brought into post.
- ✓ Clinical Referral Team established and updated birth information.
- ✓ Cardio Tocography (CTG) guidelines validated by Clinical Network and audit completed to prove compliance.
- ✓ Three additional specialist midwives recruited to the team.
- ✓ New clinical governance team structure in place.
- ✓ Partnered clinical governance review by Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) received.
- ✓ Full delivery of Saving Babies ' Lives care bundle version 2 (SBLv2).

Sands Review – Positive Feedback

The Shrewsbury and Telford Hospital NHS Trust

National Bereavement Self Assessment: Score of 90 (Champion level)

- *"…there are signs of growing unity and teamwork, commitment & enthusiasm. Staff spoke passionately about the care they provide for bereaved parents, which was highly praised – and highly valued - by the bereaved mother the team spoke with."*

- *"The staff we spoke to showed kindness and compassion … following up regularly and in person to ensure continuity of care and to ensure parents are 'held' beyond their time in the hospital setting. We heard about some examples of excellent individual care."*

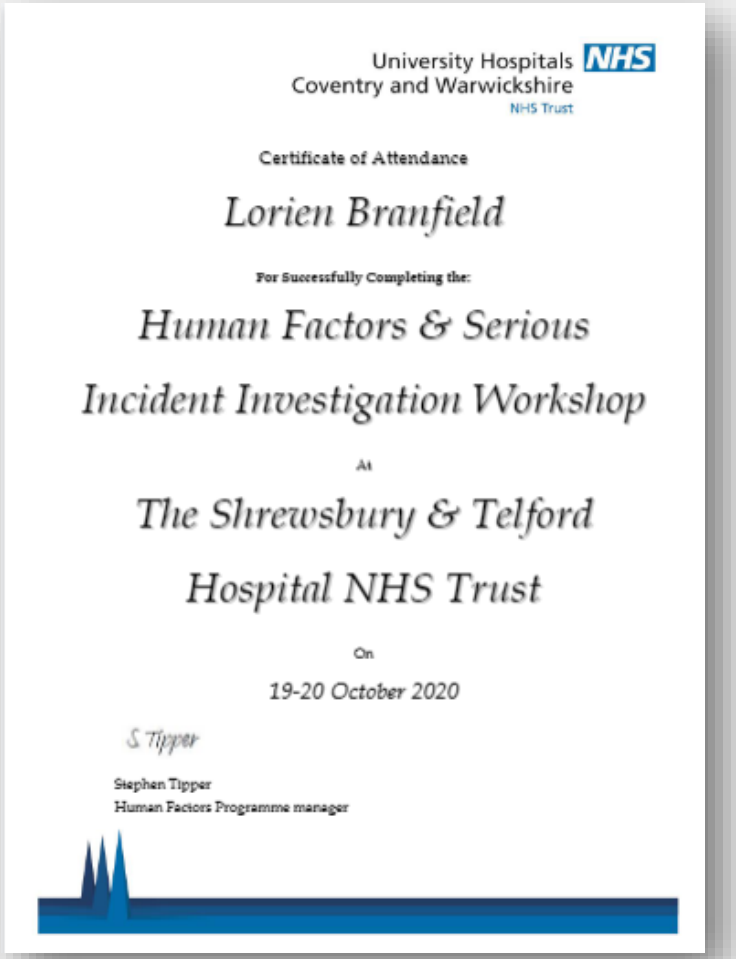
Sands Stillbirth & neonatal death charity

Theme 2 – Maternal Death

- ✓ Escalation policy for obstetric staff and midwives on when to involve the consultant has been updated and implemented, which goes beyond the Royal College of Obstetricians and Gynaecologists (RCOG) minimum standards.
- ✓ Audited compliance with escalation policy.
- ✓ Named consultant identified for all high-risk cases.
- ✓ More than 100 midwives and obstetricians undertaking Baby Lifeline's 'Improving Outcomes for those with Comorbidities in Pregnancy' and 'Enhanced Maternity Care' courses.

Work in progress: Engagement with the soon-to-be-established (Apr-22) specialist regional maternal medicine centres is in place and will inform referral pathways.

Theme 3 – Obstetric Anaesthesia



University Hospitals Coventry and Warwickshire NHS Trust

Certificate of Attendance

Lorien Branfield

For Successfully Completing the:

Human Factors & Serious Incident Investigation Workshop

At

The Shrewsbury & Telford Hospital NHS Trust

On

19-20 October 2020

S Tipper

Stephen Tipper
Human Factors Programme manager

- ✓ Anaesthetists involved in the multi-disciplinary ward rounds on the Delivery Suite.
- ✓ Anaesthetic audit requirements included in the bespoke Ockenden Report case notes audit tool.
- ✓ Anaesthetic consultants >90% compliance with online PRactical Obstetric Multi-Professional Training (PROMPT) training achieved.
- ✓ Multi-disciplinary skills-drills and simulation training taking place.
- ✓ Evidenced compliance with anaesthetics-related sections of Clinical Negligence Scheme for Trusts (CNST) Safety Action 8.

Theme 4 – Neonatal Service

- ✓ Combined nursing and medical notes implemented.
- ✓ Escalation policy to tertiary units in line with Neonatal Operational Delivery Network, British Association of Perinatal Medicine and NHSE guidelines; externally checked and validated (by NHSE/I regional colleagues).
- ✓ Rotational attachments for consultants to tertiary units in place.

Work in progress:

- Rotational attachments for Advanced Neonatal Nurse Practitioners (ANNPs) to tertiary units.
- Paperless on neonatal unit.
- Separation of Tier 2 rota from paediatrics.

Benefits Seen Through Rotational Attachments For Consultants

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Reassurance that current practice remains up to date.
- ✓ Exposure to different ventilators and new forms of respiratory support.
- ✓ Experience of management of babies with conditions outside our pathway.
- ✓ Reassurance that MDT meeting formats are similar.
- ✓ Observation of shared decision making possible due to two neonatal consultants of the day in Neonatal Intensive Care Units (NICUs).
- ✓ Exposure to different forms of handover/safety huddles leading to introduction of some of these ideas locally, e.g., nurse led handover, ‘what went well/what was challenging in the last 24 hours’.
- ✓ Team building ideas.
- ✓ Opportunity to see the Badger Electronic Patient Record (EPR) system in action.
- ✓ Idea of daily “bite size” teaching.
- ✓ Opportunity to share good practice recommendations.

Summary of Achievements - Immediate and Essential Actions (IEAs)

Mrs Annemarie Lawrence & Dr Mei-See Hon

Theme 1 – Enhanced Safety

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Strong links with LMNS/ Clinical Commissioning Group (CCG).
- ✓ Involvement of external clinical experts in investigations and Perinatal Mortality Review Tool (PMRT).
- ✓ Standard Operating Procedure (SOP) in place for involving external clinical specialists in reviews.
- ✓ Maternity and Neonatal Safety Champions group in place and conducting regular safety walkabouts:
  - Trust medical director is a key member of the monthly safety champions meeting chaired by Non-Executive Director (NED).
  - ‘You said, we did’ information fed back to staff via poster.

Maternity and Neonatal Safety Champions

The Shrewsbury and Telford Hospital NHS Trust

Who are your Safety Champions?

National Maternity Safety Champions:
Professor Jacqui Dunkley-Bent & Dr Matthew Jolly
nhsi.maternitysafetychampions@nhs.net


Non-Executive Safety Champion:
Tony Bristlin tony.bristlin@nhs.net

Trust Board level Safety Champion:
Dr John Jones john.jones1@nhs.net

Midwifery Safety Champion's:
Sarah Ellement sarah.ellement@nhs.net

Rebecca Gwilt rebecca.pentland1@nhs.net

Sara Skellern sara.skellern@nhs.net

Annemarie Lawrence annemarie.Lawrence@nhs.net

Sharon Fletcher sharon.fletcher9@nhs.net





Obstetrics Safety Champion:
Dorreh Charlesworth dorreh.charlesworth@nhs.net

Neonatal Safety Champion:
Sarah Kirk sarah.kirk2@nhs.net

Why do we have Safety Champions?

There is a national ambition to make measurable improvements in safety outcomes for women, their babies and their families who receive care from maternity and neonatal services. The national aim is to halve the rate of stillbirths, neonatal deaths, intrapartum brain injuries and maternal deaths by 2025. Maternity and Neonatal Safety Champions have been introduced to work on a national, local and Trust level to promote a culture in which better care can be delivered to women, babies and their families which is safe and evidence based.

Safety Champions

What do your Safety Champions do?

Safety Champions play a central role in ensuring mothers and babies receive the safest care possible by adopting best practice.

We have Safety Champions who are also Board Members and they engage with our staff and service users to gather their views on safety and staff satisfaction through ward walkabouts and reviewing user feedback. They ensure that Duty of Candour is upheld and that our service is following national guidelines.

We have Safety Champions who are Midwives, Obstetricians and Advanced Neonatal Nurse practitioners. They link with the Trust Board and the Local Maternity and Neonatal System to advocate for safety in their clinical areas. They will work with the Maternity Voices Partnership leads to ensure that our service is responsive to the needs of women, babies and their families.

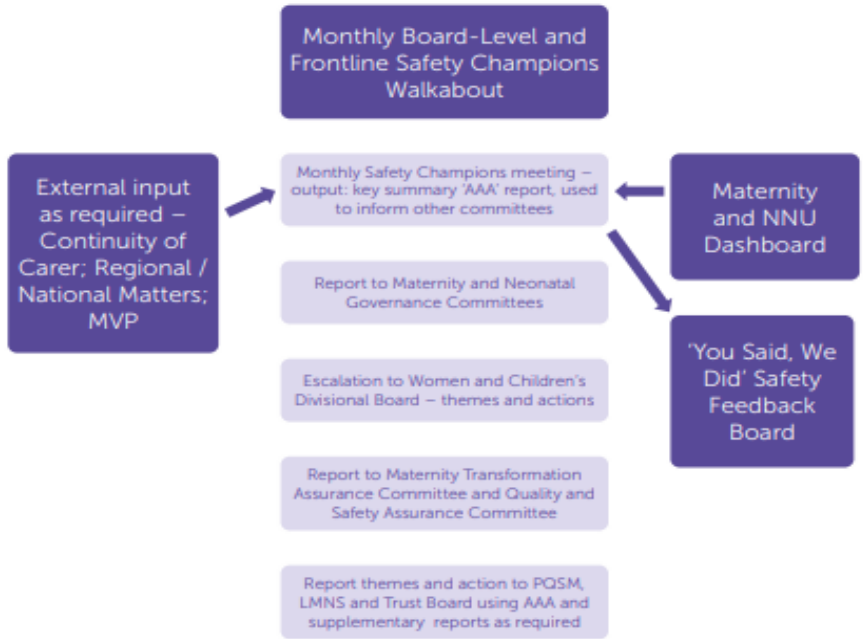
The monthly Safety Champion Walkabout is an opportunity for staff to raise and discuss any safety concerns. Feedback from these walkabouts is shared with service leads so that appropriate action plans can be developed. It is also displayed on the notice board so the team are aware of progress.

For more information, please email one of the Safety Champions.

You Said... We did...

We are constantly improving our services to meet, and exceed, the needs of our patients. Please have a look at some examples to the right of this poster.

Safety Champions Pathway



Theme 2 – Listening To Women & Families

- ✓ Maternity Voices Partnership (MVP)- SaTH co-produced 'User Experience (UX) System ' now in 4th cycle with numerous inputs received from staff and service users in total.
- ✓ Positive CQC maternity survey results
- ✓ Active Non-Executive Director and Board-level Executive participation in Safety Champions group.

Work in progress: Improvements underway to SaTH' s Information Technology (IT) platforms (e.g. website).

Positive Feedback Example

The Shrewsbury and Telford Hospital NHS Trust

'I just wanted to share some verbal feedback from a lady we have both been supporting.

*She expressed that following a recent consultation with **yourself, she felt confident in being able to ask questions and share her feelings and experiences** (much more so that she did during her first pregnancy around 6 years ago).She stated her feelings and past experiences were **really listened to, felt reassured, and felt that her choices** regarding her pregnancy and birthing options have really been **respected**. She mentioned she feels very different to how she did at the beginning of her pregnancy (in a positive way) and more able to advocate for herself.*

Thought these comments were really lovely so felt important to share.'

CQC Positive Feedback

The Shrewsbury and Telford Hospital NHS Trust

'I am delighted to inform you that The Shrewsbury and Telford Hospital NHS Trust has been identified as performing 'better than expected'. This is because the proportion of women who answered positively to questions about their care during labour and birth was significantly above the trust average. CQC would like to thank you and your teams for the work that has resulted in such positive feedback, especially during this difficult time.'

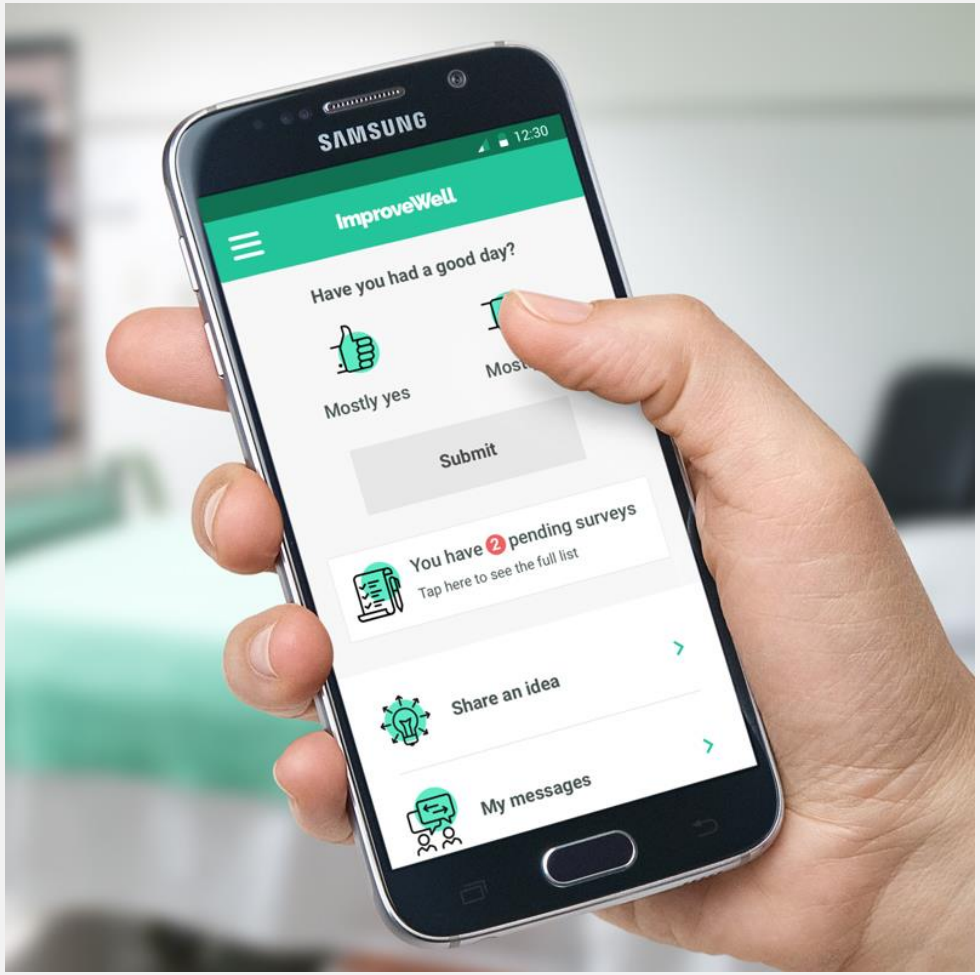
Nigel Acheson – Deputy Chief Inspector of Hospitals, 8th February 2022

Theme 3 – Staff Training & Working Together

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Pilot of Learning Management System in maternity to facilitate staff to access training.
- ✓ LMNS-funded £360k investment including simulation kit for multi-disciplinary training (MDT).
- ✓ Investment of £190k in external training, including 'Improving Outcomes for those with Comorbidities in Pregnancy' , 'Enhanced Maternal Care' , 'Learning from Adverse Events ' , 'CTG masterclass' & more.
- ✓ PROMPT yearly package, including ‘train-the-trainer’ acquired.
- ✓ Ring-fenced funding for MDT and Electronic Fetal Monitoring (EFM) training.
- ✓ Rollout of engagement app 'ImproveWell' to enhance staff engagement and boost morale.

Improvewell app



- Launched in early Feb-22. Initiative well received by staff
- 150 activated users
- >50 ideas submitted
- 6 Certificates being awarded so far
- 32% survey uptake (quarterly staff engagement survey recently launched to benchmark)

Theme 4 – Managing Complex Pregnancy

- ✓ Expansion of consultant workforce to cover 24/7 resident presence on labour ward.
- ✓ Partnership with LMNS to introduce innovative psychological support system for women experiencing loss and trauma occurring within the maternity, perinatal or neonatal context, as well as tokophobia.
- ✓ Rainbow clinic
- ✓ Specialist twins clinic in place with lead obstetricians and midwives.

Work in progress: Ongoing liaison with new soon-to-be-established regional specialist maternal medicine centres to inform referral pathways.

Theme 5 – Risk Assessments

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Introduction of new Electronic Patient Records system (Badgernet) with first bookings electronically recorded in August 2021.
- ✓ Bespoke audit tool created and in use to monitor compliance with risk assessment processes at antenatal appointments and during the intrapartum phase.

Work in progress: Rolling audit underway to ensure objectives are being met.

Theme 6 – Monitoring Fetal Wellbeing

- ✓ Fetal monitoring lead consultant and two lead midwives in post.
- ✓ Active delivery of training and improving practice - New monthly MDT face-to-face study day.
- ✓ Multiple staff have attended Baby Lifeline ' s 'CTG Masterclass' course, since November 2021.
- ✓ Annual compliance to training competency package.

Work in progress: Rolling audits of compliance with CTG guidelines.

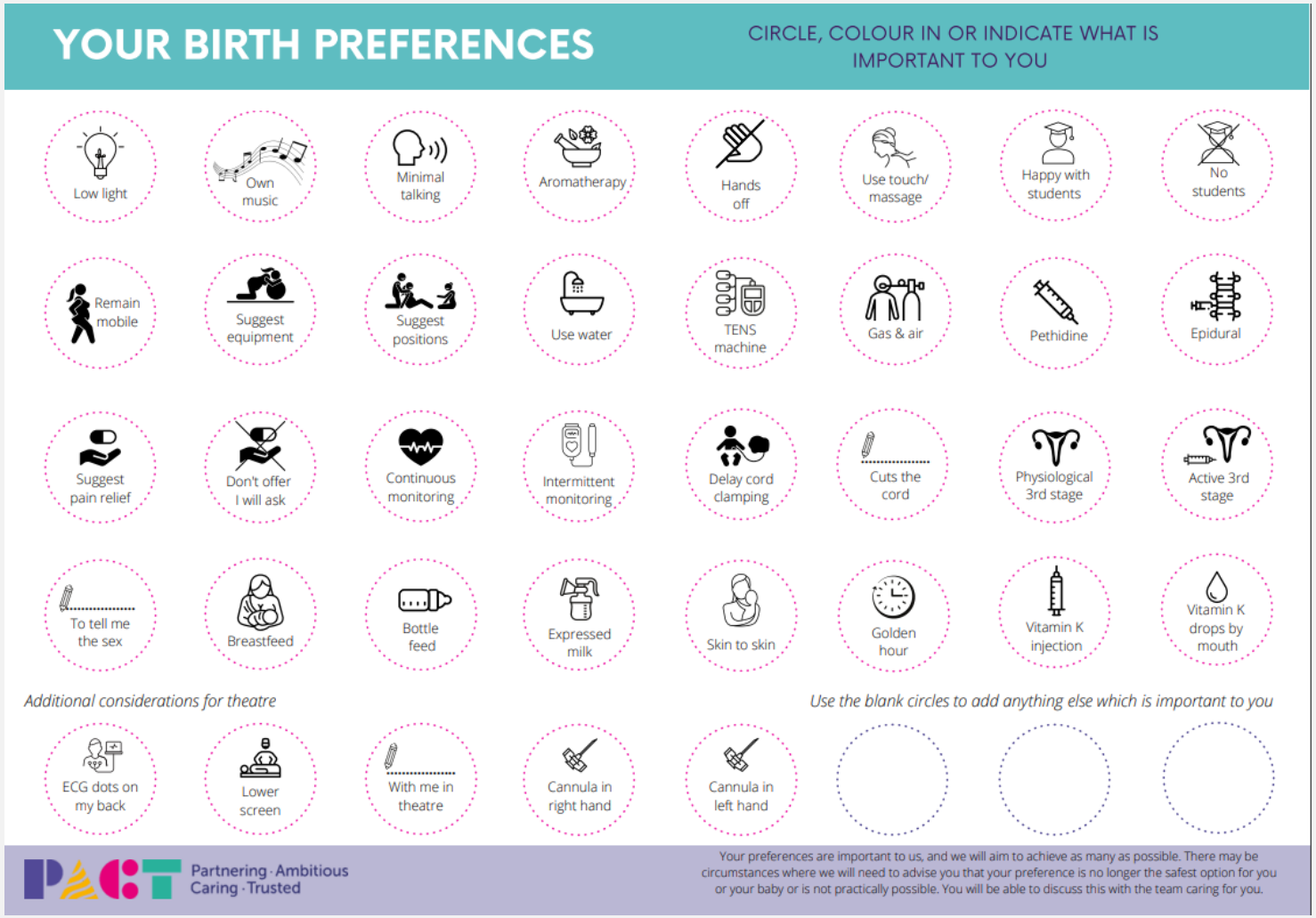
Theme 7 – Informed Consent

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Promotion of BabyBuddy app v2.0 in partnership with MVP; co-production of ‘My Personal Care and Support Plan’.
- ✓ Co-produced MVP / SaTH ‘User Experience (UX) System ’ yielding significant service user and staff input.
- ✓ New Badgernet system providing digitalised content, providing prompts where information has not been accessed, triggering staff to offer additional support.
- ✓ Increased capacity of Birth Options Clinic.
- ✓ Maternity personalised care and support planning group established with monthly meetings.
- ✓ ‘Visual Birth Preferences Card' co-produced with the MVP.

Visual Birth Preferences Card

The Shrewsbury and Telford Hospital NHS Trust



28 wk — Preferences Card explained to women and women take card home to reflect

32 wk — Midwife and service user complete card together

36 wk — Midwife and service user review/edit card

Birth — Card stays with women throughout birthing process to ensure preferences are known by staff

Conclusion

Mr Martyn Underwood

We welcome and accept all of the recommendations from the IMR.

We are committed to fully implementing and sustaining them for the benefit of our service users, families and staff.

Conclusion

The Shrewsbury and Telford Hospital NHS Trust

- To date, we have implemented 86% of Ockenden actions.
- 100% implementation of actions within SaTH's control.
- Celebrating excellent multidisciplinary working ethics and rigorous renewed governance processes are in place.
- We remain committed to listening, learning and improving.
- We have demonstrated strong partnership with the MVP and system stakeholders (e.g, CCG, LMNS and NHSEI).
- The second report is coming on the 30th March 2022. With this in mind, we commit to maintain the momentum of change.
- We acknowledge that there is still more to do.

Any questions?