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	Action complete - evidenced and assured	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
4.55	All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This W. 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	Action complete - evidenced and assured	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
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 fetal 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	Action complete - evidenced and assured	13/07/21	31/08/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
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	Action complete - evidenced and assured	13/07/21	15/07/21	14/09/21	H. Flavell	A. Lawrence	Monday.com

Colour	Status	Description
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APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

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
4.58	Staff must use NICE Guidance (2017) on fetal 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	Action complete - evidenced and assured	22/04/21	30/06/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	07/12/21	31/03/22	28/02/22	H. Flavell	A. Lawrence	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	07/12/21	31/03/22	08/03/22	H. Flavell	A. Lawrence	Monday.com
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	Action complete - evidenced and assured	22/04/21	31/05/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
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	Action complete - evidenced and assured	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	22/04/21	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com

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PROGRESS AS AT 13.02.24

APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

NHS
The Shrewsbury and Telford Hospital
NHS Trust

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	Action complete - evidenced and assured	22/04/21	28/02/22	03/02/22	H. Flavell	A. Lawrence	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	03/02/22	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com
4.66	The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	03/02/22	28/02/22	28/02/22	H. Flavell	A. Lawrence	Monday.com

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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	Action complete - evidenced and assured	22/04/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com
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	30/04/22	Delivered, Not Yet Evidenced	On Track	Exception report accepted at the Feb-24 MTAC for assurance deadline to be extended to Mar-24.	08/11/22	30/03/24		H. Flavell	G. Calcott	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	22/04/21	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com

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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	Evidenced and Assured	Completed	Action complete - evidenced and assured .	07/12/21	31/03/22	10/05/22	H. Flavell	A. Lawrence	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	07/12/21	31/03/22	10/05/22	H. Flavell	G. Dashputre	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	07/12/21	31/10/23	09/05/23	H. Flavell	A. Lawrence	Monday.com

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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	31/03/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	07/12/21	30/06/23	11/07/23	H. Flavell	A. Lawrence	Monday.com
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	31/01/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	30/09/23	12/09/23	H. Flavell	G. Dashputre	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/03/22	31/03/22	10/05/22	H. Flavell	A. Lawrence	Monday.com
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	Evidenced and Assured	Completed	Action complete - evidenced and assured	22/04/21	31/03/22	10/05/22	H. Flavell	W. Parry-Smith	Monday.com

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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	Action complete - evidenced and assured	31/03/21	30/04/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
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	Action complete - evidenced and assured	14/09/21	30/06/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
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	Action complete - evidenced and assured	12/01/21	31/10/21	14/09/21	H. Flavell	A.Sizer	Monday.com
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	31/12/23	Not Yet Delivered	On Track	Exception report accepted at the May-23 MTAC requesting deadline extensions for delivery evidence to Dec-23 and assurance evidence to Mar-24, allowing time to solve staffing issues for ANNPs to be released to visit another NICU for educational purposes.		31/03/24		H. Flavell	A.Sizer	Monday.com

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APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

IMMEDIATE AND ESSENTIAL ACTIONS (IEA): To improve Care and Safety in Maternity Services

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight													
1.1	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/03/22	28/06/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
1.2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Y	10/12/20	31/05/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/07/21	31/07/21	10/08/21	H. Flavell	A. Lawrence	Monday.com
1.3	LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.	Y	10/12/20	30/04/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/04/22	30/04/22	H. Flavell	H. Flavell	Monday.com
1.4	An LMS cannot function as one maternity service only.	Y	10/12/20	TBC	Not Yet Delivered	Off Track (see exception report)	Action to remain 'off track' following the Jan-24 MTAC. Nevertheless, progress has been made by the Division and ICB colleagues, with the assurance ('green') evidence strengthened and agreed by all parties. Another exception report will be brought to the committee once timeframes are established for the action to move back 'on track'.		TBC		H. Flavell	H. Flavell	
1.5	The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	31/01/21	30/06/21	10/08/21	H. Flavell	H. Flavell	Monday.com

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1.6	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.	Y	10/12/20	28/02/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	31/01/22	28/02/22	03/02/22	H. Flavell	A. Lawrence	Monday.com

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Immediate and Essential Action 2: Listening to Women and Families													
Maternity services must ensure that women and their families are listened to with their voices heard.													
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Y	10/12/20	30/08/24	Delivered, Not Yet Evidenced	Off Track (see exception report)	External dependent action on NHSEI. Action 'Off Track' as advocate role has resigned from role. The Feb-24 MTAC accepted the suggested timescales advised by LMNS colleagues of Aug-24 for delivery deadline and Dec-24 for assurance deadline.	12/09/23	30/12/24		H. Flavell	H. Flavell	
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Y	10/12/20	30/08/24	Not Yet Delivered	Off Track (see exception report)	External dependent action on NHSEI. Linked to IEA 2.1. Action 'Off Track' as advocate role has resigned from role. The Feb-24 MTAC accepted the suggested timescales advised by LMNS colleagues of Aug-24 for delivery deadline and Dec-24 for assurance deadline.		30/12/24		H. Flavell	H. Flavell	
2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	22/05/21	30/04/21	08/06/21	H. Flavell	A. Lawrence	Monday.com
2.4	CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.	Y	10/12/20	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC. The work to deliver this action lies with the CQC to work with the MVP at a National level, Therefore, this action lies fully outside the scope of work of the MTP.		TBC		H. Flavell	A. Lawrence	

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Immediate and Essential Action 3: Staff Training and Working Together													
Staff who work together must train together													
3.1	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/07/21	30/10/21	07/12/21	H. Flavell	W. Parry-Smith	Monday.com
3.2	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	22/04/21	30/06/21	10/08/21	H. Flavell	G. Calcott	Monday.com
3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/08/21	30/09/21	10/08/21	H. Flavell	H. Flavell	Monday.com

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Immediate and Essential Action 4: Managing Complex Pregnancies There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.													
4.1	Women with Complex Pregnancies must have a named consultant lead.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/07/21	31/10/21	04/11/21	H. Flavell	G. Calcott	Monday.com
4.2	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the women and the team.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/07/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com
4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.	Y	10/12/20	30/04/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	30/06/23	11/07/23	H. Flavell	G. Calcott	Monday.com
4.4	This must also include regional integration of maternal mental health services.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	20/04/21	30/08/22	10/05/22	H. Flavell	G. Calcott	Monday.com

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Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.													
5.1	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	22/04/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com
5.2	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	22/04/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com

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APPENDIX ONE

FIRST OCKENDEN REPORT ACTION PLAN

IEA Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Immediate and Essential Action 6: Monitoring fetal Wellbeing													
All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.													
6.1	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: * Improving the practice of monitoring fetal wellbeing * Consolidating existing knowledge of monitoring fetal wellbeing * Keeping abreast of developments in the field * Raising the profile of fetal wellbeing monitoring * Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported * Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/07/21	31/08/21	14/09/21	H. Flavell	A. Lawrence	Monday.com
6.2	The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/07/21	30/10/21	04/11/21	H. Flavell	W. Parry-Smith	Monday.com
6.3	The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Y	10/12/20	30/06/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/08/21	15/07/21	13/08/21	H. Flavell	A. Lawrence	Monday.com

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Immediate and Essential Action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.													
7.1	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/08/21	28/02/22	03/02/22	H. Flavell	G. Calcott	Monday.com
7.2	Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.	Y	10/12/20	31/07/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/08/21	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com
7.3	Women's choices following a shared and informed decision making process must be respected	Y	10/12/20	31/03/21	Evidenced and Assured	Completed	Action complete - evidenced and assured	22/04/21	28/02/22	28/02/22	H. Flavell	G. Calcott	Monday.com

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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Local Actions For Learning Theme 1: Improving Management of Patient Safety Incidents													
14.1	Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as it is superseded by the upcoming National implementation of PSIRF.		TBC		H. Flavell	A. Lawrence	
14.2	The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	On Track	Action approved as 'delivered, not yet evidenced' at Aug-23 MTAC		31/03/24		H. Flavell	A. Lawrence	
14.3	All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	31/01/23	11/10/22	H. Flavell	A. Lawrence	Monday.com
14.4	The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	31/01/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
14.5	Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	31/01/23	13/09/22	H. Flavell	A. Lawrence	Monday.com
14.6	All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/03/24	10/01/23	H. Flavell	A. Lawrence	Monday.com
14.7	All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	31/08/23	14/02/23	H. Flavell	A. Lawrence	Monday.com

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PROGRESS AS AT 13.02.24

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FINAL OCKENDEN REPORT ACTION PLAN

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14.8	The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	31/05/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
14.9	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 2: Patient and Family Involvement													
14.10	The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence	Monday.com
14.11	All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence	Monday.com
14.12	The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.	Y	30/03/22	30/09/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/07/23	31/01/24	13/12/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 3: Support for Staff													
14.13	There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/08/22	30/04/23	11/10/22	H. Flavell	A. Lawrence	Monday.com
14.14	The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/03/24	13/12/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 4: Improving Complaints Handling													
14.15	Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/10/22	31/01/23	10/01/23	H. Flavell	A. Lawrence	Monday.com
14.16	Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/08/23	13/12/22	H. Flavell	A. Lawrence	Monday.com
14.17	All staff involved in preparing complaint responses must receive training in complaints handling.	Y	30/03/22	30/06/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/06/23	31/12/23	14/12/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 5: Improving Audit Process													
14.18	There must be midwifery and obstetric co-leads for audits.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence & A. Sizer	Monday.com
14.19	Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	J. Jones	A. Lawrence & A. Sizer	Monday.com
14.20	Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com
14.21a	Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	30/04/23	11/04/23	H. Flavell	A. Lawrence	Monday.com
14.21b	Matters arising from clinical incidents must contribute to the annual audit plan.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 6: Improving Guidelines Process													
14.22	There must be midwifery and obstetric co-leads for developing guidelines.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence & A. Sizer	Monday.com
14.23	A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/08/22	31/01/23	14/02/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 7: Leadership and Oversight													
14.24	The Trust Board must review the progress of the maternity improvement and transformation plan every month.		30/03/22	31/07/2023	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/08/23	31/10/23	14/11/23	H. Flavell	H. Flavell	
14.25	The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment235 Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.		30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	C. McInnes	Monday.com
14.26	The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive		30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/10/22	31/01/23	13/12/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 8: Care of Vulnerable and High Risk Women													
14.27	The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/10/22	30/04/23	11/10/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 9: Fetal Growth Assessment and Management													
14.28	The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence	Monday.com
14.29	Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019).	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 10: Fetal Medicine Care													
14.30	The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	On Track	Action accepted as 'delivered, not yet evidenced' at the Oct-23 MTAC.	10/10/23	31/03/24		H. Flavell	A.Sizer	
14.31	Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	On Track	Action accepted as 'delivered, not yet evidenced' at the Oct-23 MTAC.	10/10/23	31/03/24		H. Flavell	A.Sizer	

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Local Actions For Learning Theme 11: Diabetes Care													
14.32	The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.	Y	30/0322	30/11/23	Delivered, Not Yet Evidenced	At Risk (see exception report)	Exception report accepted at the Nov-23 MTAC to move this action from 'on track' to 'at risk' as the final Mar-24 deadline will not be met. This is because the delivery of the actions is linked to the approval of further funding outlined in the new Ockenden Business Case. Impacted actions are as follows: IEA 4.3, IEA 8.1, IEA 11.1, IEA 14.8, LAFL 14.32, LAFL 14.52, LAFL 14.57 and LAFL 14.59.	13/09/22	TBC		H. Flavell	C. McInnes	Monday.com

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Local Actions For Learning Theme 12: Hypertension													
14.33	Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/10/22	31/08/23	08/08/23	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 13: Consultant Obstetric Ward Rounds and Clinical Review													
14.34	All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017237). These consultant reviews must occur with a clearly documented plan recorded in the maternity records	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/08/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.35	All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/10/22	30/04/23	10/01/22	H. Flavell	A. Sizer	Monday.com
14.36	The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR239 to enable all staff to escalate and communicate their concerns.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence & C. McInnes	Monday.com

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LAFL Ref	Action required	Linked to associated plans (e.g. MIP / MTP)	Start Date	Due Date	Delivery Status	Progress Status	Status Commentary (This Period)	Actual Completion Date	Date to be evidenced by	Date evidenced by	Accountable Executive	Accountable Person	Location of Evidence
Local Actions For Learning Theme 14: Escalation Of Concerns													
14.37	The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/04/23	31/08/23	11/04/23	H. Flavell	A. Lawrence	Monday.com
14.38	The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.	Y	30/03/22	31/10/23	Delivered, Not Yet Evidenced	On Track	Assurance deadline extension accepted to Mar-24, at the Feb-24 MTAC	14/11/23	30/03/24		H. Flavell	A. Lawrence	
14.39	The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 15: Multidisciplinary Working													
14.40	The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/06/23	31/08/23		H. Flavell	C. McInnes	Monday.com
14.41	The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/04/23	31/08/23	11/04/23	H. Flavell	A. Lawrence	Monday.com
14.42	There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence & A. Sizer	Monday.com
14.43	Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/08/23	31/03/24	14/12/23	H. Flavell	A. Lawrence, A.Sizer & C. McInnes	Monday.com
14.44	All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/06/23	31/08/23	11/07/23	H. Flavell	A. Lawrence & C. McInnes	Monday.com

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Local Actions For Learning Theme 16: fetal Assessment and Monitoring													
14.45	Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	31/01/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.46a	The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence, A. Sizer & C. McInnes	Monday.com
14.46b	Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/08/23	13/12/22	H. Flavell	A. Lawrence & A. Sizer	Monday.com

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Local Actions For Learning Theme 17: Specific to Midwifery-Led Units and Out-Of-Hospital Births													
14.47	Midwifery-led units must complete yearly operational risk assessments.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/08/23	13/12/22	H. Flavell	A. Lawrence	Monday.com
14.48	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence	Monday.com
14.49	It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence	Monday.com

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Local Actions For Learning Theme 18: Maternal Deaths													
14.50	In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/07/23	31/03/24	08/08/23	J. Jones	A. Sizer	Monday.com

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Local Actions For Learning Theme 19: Obstetric Anaesthesia													
14.51	The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	31/08/23	14/02/23	J. Jones	G. Dashputre	Monday.com
14.52	The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.	Y	30/03/22	TBC	Not Yet Delivered	At Risk (see exception report)	Exception report accepted at the Nov-23 MTAC to move this action from 'on track' to 'at risk' as the final Mar-24 deadline will not be met. This is because the delivery of the actions is linked to the approval of further funding outlined in the new Ockenden Business Case. Impacted actions are as follows: IEA 4.3, IEA 8.1, IEA 11.1, IEA 14.8, LAFL 14.32, LAFL 14.52, LAFL 14.57 and LAFL 14.59.		TBC		H. Flavell	J. Jones	
14.53	The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020.	Y	30/03/22	30/06/24	Not Yet Delivered	On Track	Exception report accepted at the Feb-24 MTAC requesting a delivery deadline extension to Jun-24 and assurance deadline extension to Aug-24		30/08/24		H. Flavell	J. Jones	
14.54	The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	31/03/24	09/05/23	H. Flavell	J. Jones	Monday.com
14.55	The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.	Y	30/03/22	30/06/24	Not Yet Delivered	On Track	Exception report accepted at the Feb-24 MTAC requesting a delivery deadline extension to Jun-24 and assurance deadline extension to Aug-24		30/08/24		H. Flavell	J. Jones	

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Local Actions For Learning Theme 20: Neonatal													
14.56	The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Sizer	Monday.com
14.57	As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	At Risk (see exception report)	Action accepted as 'delivered, not yet evidenced' at the Nov-23 MTAC. Exception report accepted at the Nov-23 MTAC to move this action from 'on track' to 'at risk' as the final Mar-24 deadline will not be met. This is because the delivery of the actions is linked to the approval of further funding outlined in the new Ockenden Business Case. Impacted actions are as follows: IEA 4.3, IEA 8.1, IEA 11.1, IEA 14.8, LAFL 14.32, LAFL 14.52, LAFL 14.57 and LAFL 14.59.	14/11/23	TBC		H. Flavell	C. McInnes	
14.58	The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	C. McInnes	Monday.com
14.59	The number of neonatal nurses at the Trust who are “qualified-in-specialty” must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.	Y	30/03/22	31/12/22	Delivered, Not Yet Evidenced	At Risk (see exception report)	Action accepted as 'delivered, not yet evidenced' at Dec-22 MTAC. Exception report accepted at the Nov-23 MTAC to move this action from 'on track' to 'at risk' as the final Mar-24 deadline will not be met. This is because the delivery of the actions is linked to the approval of further funding outlined in the new Ockenden Business Case. Impacted actions are as follows: IEA 4.3, IEA 8.1, IEA 11.1, IEA 14.8, LAFL 14.32, LAFL 14.52, LAFL 14.57 and LAFL 14.59.	13/12/22	TBC		H. Flavell	C. McInnes	Monday.com

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Local Actions For Learning Theme 21: Postnatal													
14.60	The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and assured	13/12/22	31/08/23	12/09/23	H. Flavell	A. Sizer	Monday.com
14.61	The Trust must ensure complete and accurate information is given to families after any poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and assured	11/04/23	31/08/23	12/09/23	H. Flavell	A. Sizer	

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Local Actions For Learning Theme 22: Staff Voices													
14.62	The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey.	Y	30/11/23	30/11/23	Delivered, Not Yet Evidenced	On Track	Action accepted as 'delivered, not yet evidenced' at the Oct-23 MTAC. This action comprises two subitems. It is likely that they will be assured by Mar-24. Progress status for this action is currently at 'on track' as the action is being addressed as part of the cultural improvement work undertaken as part of the MTP. Nevertheless, this action will take time to fully implement as it is dependent on various assurance pieces (action plan implementation, cultural assesments, etc.)	10/10/23	31/03/24		H. Flavell	C. McInnes	

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PROGRESS AS AT 13.02.24

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The Shrewsbury and Telford Hospital NHS Trust

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Local Actions For Learning Theme 23: Supporting Families After the Review is Published													
14.63	Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	14/02/23	J. Jones	H. Flavell	Monday.com
14.64	There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action is fully dependent on NHSEI, commissioners and Mental Health Trusts. Thereby this action lies fully outside the scope of work of the MTP.		TBC		J. Jones	H. Flavell	

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IMMEDIATE AND ESSENTIAL ACTIONS (IEA): To improve Care and Safety in Maternity Services

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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. We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.													
1.1	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.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action is fully dependent on NHSEI funding plans. Thereby this action lies fully outside the scope of work of the MTP.		TBC		J. Jones	H. Flavell	
1.2	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.	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	At Risk (see exception report)	Exception report accepted at the Dec-23 MTAC requesting this action is flagged as 'at risk', due to the unlikelihood of the action meeting the Mar-24 deadline. This action has been outlined in the Ockenden Business Case, as is linked to funding, and is going through the suitable governance proceses.	10/01/23	31/03/24		J. Jones	H. Flavell	
1.3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and assured	13/09/23	31/03/24	13/09/23	H. Flavell	C. McInnes	
1.4	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	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies (NHSE, RCOG, RCM and RCPCH) . Thereby this action lies fully outside the scope of work of the MTP.		TBC		J. Jones	H. Flavell	
1.5	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.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and assured	08/11/22	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com

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1.6	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 practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	28/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.7	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.	Y	30/03/22	TBC	Delivered, Not Yet Evidenced	At Risk (see exception report)	Action 'rescoped' at the Jan-24 MTAC; as the programme has been approved Nationally. However, it is unlikely that all staff will complete it by the Mar-24 deadline. Hence, the action flagged as 'at risk'.		TBC		H. Flavell	A. Lawrence	
1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	31/08/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and assured	13/06/23	31/03/24	12/09/23	H. Flavell	A. Lawrence	Monday.com
1.10	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.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - Evidenced and assured	11/07/23	31/03/24	14/12/23	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com

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1.11	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.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies(RCOG and RCP). Thereby this action lies fully outside the scope of work of the MTP.		TBC		J. Jones	H. Flavell	

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Immediate and Essential Action 2: Safe Staffing All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.													
2.1	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	31/01/23	13/09/22	H. Flavell	C. McInnes	Monday.com
2.2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Sizer	Monday.com
2.3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/08/22	31/01/23	09/08/22	H. Flavell	A. Lawrence	Monday.com
2.4	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.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/08/22	31/08/23	09/08/22	H. Flavell	A. Lawrence	Monday.com
2.5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/08/22	31/08/23	09/08/22	H. Flavell	A. Lawrence	Monday.com
2.6	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 for generic trust mandatory training and reviewed as training requirements change.	Y	30/03/22	31/12/23	Delivered, Not Yet Evidenced	On Track	Action moved from 'delivered, not yet evidenced' to 'not yet delivered' due to new CNST requirement, via an exception report at Sep-23 MTAC. New delivery and assurance deadlines approved. Action accepted as 'delivered, not yet evidenced' at Oct-23 MTAC	10/10/23	31/03/24		H. Flavell	A.Sizer	Monday.com
2.7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	30/04/23	13/12/22	H. Flavell	A. Lawrence	Monday.com

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2.8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	30/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
2.9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	31/01/23	11/10/22	H. Flavell	A. Lawrence	Monday.com
2.10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com

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Immediate and Essential Action 3: Escalation and Accountability Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.													
3.1	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.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/04/23	31/08/23	09/05/23	H. Flavell	A. Lawrence	Monday.com
3.2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	31/01/23	13/09/22	H. Flavell	A. Sizer	Monday.com
3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/05/22	30/09/22	15/06/22	H. Flavell	A. Sizer	Monday.com
3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/10/22	31/01/23	11/10/22	H. Flavell	A. Sizer, C. McInnes, A. Lawrence	Monday.com

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Immediate and Essential Action 4: Clinical Governace - Leadership Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.													
4.1	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/06/22	31/01/24	14/11/23	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	Monday.com
4.2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	C. McInnes	Monday.com
4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Y	30/03/22	TBC	Not Yet Delivered	At Risk (see exception report)	Exception report accepted at the Nov-23 MTAC to move this action from 'on track' to 'at risk' as the final Mar-24 deadline will not be met. This is because the delivery of the actions is linked to the approval of further funding outlined in the new Ockenden Business Case. Impacted actions are as follows: IEA 4.3, IEA 8.1, IEA 11.1, IEA 14.8, LAFL 14.32, LAFL 14.52, LAFL 14.57 and LAFL 14.59.		TBC		J. Jones	H. Flavell	
4.4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
4.5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/04/23	31/08/23	11/04/23	H. Flavell	A. Lawrence	Monday.com
4.6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com
4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/05/22	30/09/22	15/06/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com

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Immediate and Essential Action 5: Clinical Governance - Incident Investigation and Complaints Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.													
5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	30/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/08/22	31/01/23	13/09/22	H. Flavell	A. Sizer, A. Lawrence	Monday.com
5.3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/04/23	31/08/23	11/04/23	H. Flavell	A. Lawrence, A. Sizer	Monday.com
5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/05/23	31/08/23	09/05/23	H. Flavell	A. Sizer, A. Lawrence	Monday.com
5.5	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	30/04/23	14/02/23	H. Flavell	A. Lawrence	Monday.com
5.6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent	Y	30/03/22	31/10/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/01/23	31/01/23	10/01/23	H. Flavell	A. Lawrence	Monday.com
5.7	Complaints themes and trends must be monitored by the maternity governance team.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/05/22	30/09/22	15/06/22	H. Flavell	A. Lawrence	Monday.com

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Immediate and Essential Action 6: Learning from Maternal deaths Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.													
6.1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies(Royal Colleges). Thereby this action lies fully outside the scope of work of the MTP.		TBC		J. Jones	H. Flavell	
6.2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	30/04/23	14/02/23	J. Jones	H. Flavell	Monday.com
6.3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/01/23	31/08/23	09/05/23	H. Flavell	A. Sizer, A. Lawrence	Monday.com

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Immediate and Essential Action 7: Multidisciplinary Training Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.													
7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/08/23	31/03/24	13/12/23	H. Flavell	C. McInnes	Monday.com
7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/05/22	30/09/22	15/06/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.3	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.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/07/23	31/03/24	09/01/24	H. Flavell	C. McInnes, A. Sizer, A. Lawrence	
7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Sizer	Monday.com
7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/05/22	30/09/22	15/06/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	09/08/22	31/01/23	09/08/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com
7.7	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	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/03/24	13/12/22	H. Flavell	C. McInnes, A. Lawrence, A. Sizer	Monday.com

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Immediate and Essential Action 8: Complex Antenatal Care Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.													
8.1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Y	30/03/22	TBC	Not Yet Delivered	At Risk (see exception report)	Exception report accepted at the Nov-23 MTAC to move this action from 'on track' to 'at risk' as the final Mar-24 deadline will not be met. This is because the delivery of the actions is linked to the approval of further funding outlined in the new Ockenden Business Case. Impacted actions are as follows: IEA 4.3, IEA 8.1, IEA 11.1, IEA 14.8, LAFL 14.32, LAFL 14.52, LAFL 14.57 and LAFL 14.59.		TBC		H. Flavell	A.Sizer	
8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	30/04/23	14/02/23	H. Flavell	A. Sizer	Monday.com
8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	30/04/23	09/05/23	H. Flavell	A. Sizer	Monday.com
8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	31/08/23	08/08/23	H. Flavell	A. Sizer	Monday.com

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Immediate and Essential Action 9: Preterm Birth The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)													
9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/04/23	31/08/23	11/04/23	H. Flavell	A. Sizer	Monday.com
9.2	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.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/01/23	30/04/23	10/01/23	H. Flavell	A. Sizer	Monday.com
9.3	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.	Y	30/03/22	28/02/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/04/23	30/04/23	11/04/23	H. Flavell	J. Jones	Monday.com
9.4	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019) There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Y	30/03/22	TBC	Evidenced and Assured	Completed	Action accepted as 'Evidenced and Assured' at Sep-23 MTAC.	14/02/23	TBC	12/09/23	H. Flavell	A. Sizer	

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Immediate and Essential Action 10: Labour and Birth Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units													
10.1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/23	30/04/23	11/04/23	H. Flavell	A. Lawrence, A. Sizer	Monday.com
10.2	Midwifery-led units must complete yearly operational risk assessments.	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	13/09/22	H. Flavell	A. Lawrence	Monday.com
10.3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence	Monday.com
10.4	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	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	08/11/22	30/04/23	08/11/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com
10.5	Maternity units must have pathways for Induction of labour (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - Evidenced and assured	08/11/22	30/09/23	12/09/23	H. Flavell	A. Lawrence, A. Sizer	Monday.com
10.6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Sizer	Monday.com

Colour	Status	Description
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APPENDIX ONE

FINAL OCKENDEN REPORT ACTION PLAN

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Immediate and Essential Action 11: Obstetric Anaesthesia In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.												
11.1	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.	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	At Risk (see exception report)	Exception report accepted at the Nov-23 MTAC to move this action from 'on track' to 'at risk' as the final Mar-24 deadline will not be met. This is because the delivery of the actions is linked to the approval of further funding outlined in the new Ockenden Business Case. Impacted actions are as follows: IEA 4.3, IEA 8.1, IEA 11.1, IEA 14.8, LAFL 14.32, LAFL 14.52, LAFL 14.57 and LAFL 14.59.	08/11/22	TBC		H. Flavell	J. Jones	Monday.com
11.2	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	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - Evidenced and assured	11/04/23	31/08/23	12/09/23	H. Flavell	J. Jones	
11.3	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	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	This action was accepted as 'Evidenced and Assured' at the Feb-23 MTAC.	14/02/23	31/08/23	14/02/23	H. Flavell	J. Jones	Monday.com
11.4	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.	Y	30/03/22	TBC	Not Yet Delivered	Descoped (see exception report)	Action accepted as 'Descoped' at the Feb-23 MTAC as the action fully dependent on National bodies (RCoA) obtaining resources. Thereby this action lies fully outside the scope of work of the MTP.		TBC		H. Flavell	J. Jones	
11.5	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.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - 'evidenced and assured' at the Aug-23 MTAC	14/02/23	31/08/23	08/08/23	H. Flavell	J. Jones	Monday.com

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11.6	Obstetric anaesthesia staffing guidance to include: 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	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	14/02/23	31/10/23	14/11/23	H. Flavell	J. Jones	Monday.com
11.7	Obstetric anaesthesia staffing guidance to include: The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/12/23	14/11/23	H. Flavell	J. Jones	Monday.com
11.8	Obstetric anaesthesia staffing guidance to include: Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/01/23	10/01/23	H. Flavell	J. Jones	Monday.com

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Immediate and Essential Action 12: Postnatal Care Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times.													
12.1	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.	Y	30/03/22	30/11/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/12/22	31/03/24	13/12/22	H. Flavell	A. Sizer	Monday.com
12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	At Risk (see exception report)	Exception report accepted at the Dec-23 MTAC requesting this action is flagged as 'at risk', due to the unlikelihood of the action meeting the Mar-24 deadline. This action has been outlined in the Ockenden Business Case, as is linked to funding, and is going through the suitable governance proceses	13/12/22	31/03/24		H. Flavell	A.Sizer	Monday.com
12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	Y	30/03/22	30/11/23	Delivered, Not Yet Evidenced	At Risk (see exception report)	Exception report accepted at the Dec-23 MTAC requesting this action is flagged as 'at risk', due to the unlikelihood of the action meeting the Mar-24 deadline. This action has been outlined in the Ockenden Business Case, as is linked to funding, and is going through the suitable governance proceses	13/12/22	31/03/24		H. Flavell	A.Sizer	Monday.com
12.4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	This action was accepted as 'Evidenced and Assured' at the Feb-23 MTAC.	14/02/23	31/08/23	14/02/23	H. Flavell	A. Sizer, A. Lawrence	Monday.com

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Immediate and Essential Action 13: Bereavement Care Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.													
13.1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday	Y	30/03/22	30/09/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	12/07/22	31/01/23	12/07/22	H. Flavell	A. Lawrence	Monday.com
13.2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/10/22	31/10/23	14/11/23	H. Flavell	A. Lawrence	Monday.com
13.3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	10/05/22	30/09/22	14/06/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com
13.4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway	Y	30/03/22	31/07/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	11/05/22	30/09/22	15/06/22	H. Flavell	A. Lawrence, A. Sizer	Monday.com

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Immediate and Essential Action 14: Neonatal Care There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.													
14.1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	28/02/23	13/09/22	J. Jones	H. Flavell	Monday.com
14.2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.4	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.	Y	30/03/22	31/12/23	Not Yet Delivered	Off Track (see exception report)	Action 'off track' as the ANNPs have not visited another NICU for educational purposes as of yet, due to operational pressures. An exception report will be brought to the Mar-24 MTAC with new deadine proposals.		31/03/24		J. Jones	H. Flavell	Monday.com
14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	Y	30/03/22	TBC	Delivered, Not Yet Evidenced	Descoped (see exception report)	Action approved as 'delivered, not yet evidenced' at July MTAC as the Trust has been providing the Network with all the requested reports. Action accepted as 'Descoped' at the Feb-23 MTAC as the action is now within the hands of the Network to progress. Thereby this action lies fully outside the scope of work of the MTP.	12/07/22	TBC		J. Jones	H. Flavell	Monday.com
14.6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Y	30/03/22	31/05/23	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	31/08/23	11/04/23	H. Flavell	A. Sizer	Monday.com

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14.7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm	Y	30/03/22	31/12/22	Evidenced and Assured	Completed	Action complete - evidenced and assured	13/09/22	30/04/23	13/09/22	H. Flavell	A. Sizer	Monday.com
14.8	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.	Y	30/03/22	TBC	Not Yet Delivered	At Risk (see exception report)	Exception report accepted at the Nov-23 MTAC to move this action from 'on track' to 'at risk' as the final Mar-24 deadline will not be met. This is because the delivery of the actions is linked to the approval of further funding outlined in the new Ockenden Business Case. Impacted actions are as follows: IEA 4.3, IEA 8.1, IEA 11.1, IEA 14.8, LAFL 14.32, LAFL 14.52, LAFL 14.57 and LAFL 14.59.		TBC		H. Flavell	C. McInnes, A.Sizer	Monday.com

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Immediate and Essential Action 15: Supporting Families Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care													
15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	This action was accepted as 'Evidenced and Assured' at the Feb-23 MTAC.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	
15.2	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.	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	This action was accepted as 'Evidenced and Assured' at the Feb-23 MTAC.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	
15.3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	Y	30/03/22	30/04/23	Evidenced and Assured	Completed	This action was accepted as 'Evidenced and Assured' at the Feb-23 MTAC.	14/02/23	30/04/23	14/02/23	H. Flavell	C. McInnes	

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Glossary and Index to the Ockenden Report Action Plan

Colour coding: Delivery Status

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

Colour coding: Progress Status

Colour	Status	Description
	Not started	Work on the tasks required to deliver this action has not yet started.
	Off track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At risk	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where
	On track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that this action is being delivered and sustained.
	Descoped	The work to deliver this action is not within the Trust's control to deliver. It is therefore descoped until such time that Local or National progress is made to enable the Trust to implement and embed this action.

Accountable Executive and Owner Index

Name	Title and Role	Project Role
Hayley Flavell	Executive Director of Nursing	Overall MTP Executive Sponsor
John Jones	Executive Medical Director	Overall MTP Executive co-sponsor
Andrew Sizer	Medical Director, Women & Children's Division	Senior Responsible Officer, MTP and Accountable Action Owner
Carol McInnes	Director of Operations, Women & Children's Division	Accountable Action Owner
Mei-See Hon	Clinical Director, Obstetrics	Co-lead: Clinical quality and choice workstream and lead for 'User Experience' system
Annemarie Lawrence	Director of Midwifery	Lead: Maternity Improvement Plan and Accountable Action Owner
Guy Calcott	Obstetric Consultant	Co-lead: Clinical Quality and Choice Workstream
Kim Williams	Head of Midwifery	Lead: Communications and Engagement workstream/Clinical Governance and Risk
Dudu Nyathi	Consultant Midwife	Lead: Learning, Partnerships and Research Workstream
Rhia Boyode	Executive Director of Workforce and OD	Lead: People and Culture workstream
Gauri Dashputre	Consultant Anaesthetist	Lead: Anaesthetics workstream

Ockenden 1

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	27	1	1	25
IEA	25	3	1	21
Total	52	4	2	46

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	27	0	2	0	0	25	0
IEA	25	0	0	0	3	21	1
Total	52	0	2	0	3	46	1

Ockenden 2

Delivery Status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	66	5	8	53
IEA	92	9	7	76
Total	158	14	15	129

Progress Status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	66	0	7	4	0	53	2
IEA	92	0	1	8	1	76	6
Total	158	0	8	12	1	129	8

Combined actions - Delivery status

Action Type	Total number of actions	Not yet delivered	Delivered, Not Yet Evidenced	Evidenced and Assured
LAFL	93	6	9	78
IEA	117	12	8	97
Total	210	18	17	175

Combined actions- Progress status

Action Type	Total number of actions	Not Started	On Track	At Risk (see exception report)	Off Track (see exception report)	Completed	Descoped (See exception report)
LAFL	93	0	9	4	0	78	2
IEA	117	0	1	8	4	97	7
Total	210	0	10	12	4	175	9

APPENDIX 2

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting
January 2024

Agenda item				
Report Title	ATAIN (Avoiding Term Admissions into Neonatal Units) report. Quarter 3 2023-24			
Executive Lead	Hayley Flavell			
Report Author	Jo Kench Women and Children's Quality Governance Officer			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information	√		
	For consent			
Presented to:	**Maternity and Neonatal Governance Meetings October 2023**			
Executive summary:	• Rate of admissions to the Neonatal unit for babies >37 weeks is 6.5% for Quarter 3 • This is just above the national target of 6% and a slight increase from quarter 2 this year. • The most common reasons for admission for admission are respiratory conditions and infection. • All cases are reviewed in a fortnightly meeting with MDT representation from Obstetrics, Neonatology, Maternity, and the Governance team.			
Appendices				
Executive Lead	Hayley Flavell, Director of Nursing			

ATAIN (Avoiding Term Admissions into Neonatal Units) Report for Q2 2023

Background

Admission to a neonatal unit can lead to unnecessary separation of mother and baby. There is overwhelming evidence that separating mother and baby at or soon after birth can affect the positive development of the mother-child attachment process and adversely affect maternal perinatal mental health.

Preventing separation except for compelling medical indications is essential in providing safe maternity services.

NHS providers of maternal and neonatal care can use data collected through ATAIN reviews as a resource to:

- Improve the safety of care.
- Keep mothers and babies together whenever it is safe to do so.
- Identify local improvement priorities.

Improving the safety of maternity services is a key priority for the NHS and the number of unexpected admissions of full-term babies (i.e., those born at 37 weeks or more), is seen as a proxy indicator that harm may have been caused at some point along the maternity or neonatal pathway.

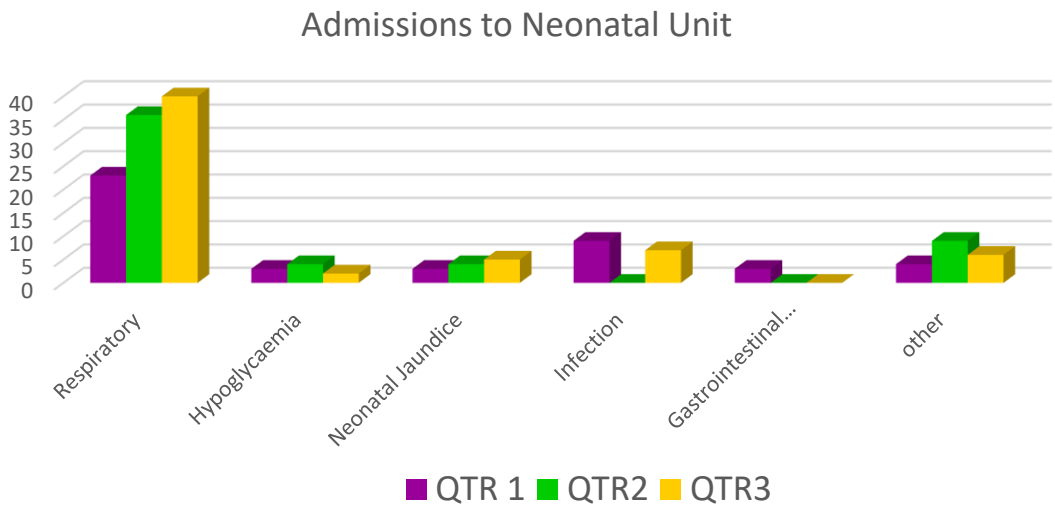
ATAIN focuses on four key clinical areas that represent a significant amount of potentially avoidable harm to babies:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischemia)

Review Systems

Multi-Disciplinary Team (MDT) meetings continue fortnightly to review all cases which meet the ATAIN criteria. Term admissions to the neonatal unit are currently monitored utilising the neonatal BadgerNet digital system, Datix submissions, and a manual check of the Neonatal Unit admissions book. A cross reference is made with all three systems as a failsafe to ensure that no case is missed. The metrics collated from these meetings are presented quarterly for assurance, at both Maternity and Neonatal Governance meetings. Any safety concerns are immediately escalated, and any learning is shared with the multi-disciplinary teams in both areas.

The rate of term admissions to the neonatal unit are calculated as a percentage of live, **term** births in line with the NHS Improvement “Reducing harm leading to avoidable admission of full-term babies into neonatal units” paper from 2017.



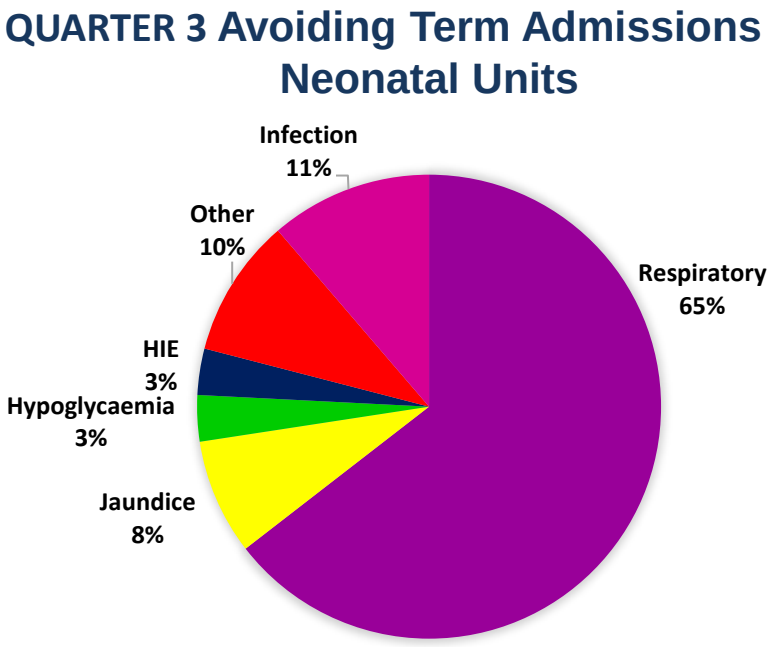
1.0 Rates

The term admission rate for Q3 (Oct-Dec 2023) was 6.5% of all births at >37 weeks, an increase from the previous Q2 figure of 6.0%. The year-to-date term admission rate is 5.6%. This rate is at the national target of 6.0%.

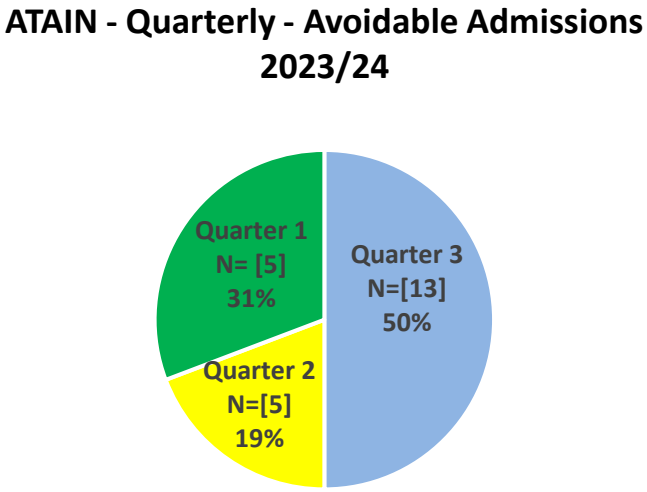
A total of 62 term babies were admitted to the NNU in Q3 2023 (comparing with 57 in the previous quarter.)

The numbers of babies admitted each month were:
Oct 2023 7.0% of all births at >37 weeks (n = 23)
Nov 2023 7.4 % of all births at >37 weeks (n = 25)
Dec 2023 4.4% of all births at >37 weeks (n = 13)

2.0 Quarter 3 Metrics



2.1 Avoidable Admissions -2023/24



3.0 Reason for admission

3.1 Respiratory conditions

Respiratory conditions continue to make up most admissions to the NNU, with 40 babies this quarter. 20 of which were caesarean births, 14 were emergency caesarean births (4 of which were not in labour) and 6 electives. Two of the respiratory admissions were a ventouse birth, 1 baby born by forceps and 18 spontaneous vaginal births. 33 of the babies received Antibiotics during their stay.

Mothers booked for elective caesarean sections prior to 39 weeks gestation are routinely offered the option of antenatal corticosteroids to reduce the risk of neonatal respiratory morbidity as per the 'Caesarean Section – Emergency and Elective' Guideline. The ATAIN review group monitor whether the parents received informed discussion regarding steroids and document this conversation and its outcome in the notes. One of the elective caesarean sections was conducted prior to 39 weeks gestation for appropriate reasons and parents received counselling.

3.2 Hypoglycaemia

During quarter 2, there were 2 babies (all born to diabetic mothers) admitted to the neonatal unit due to hypoglycaemia. 2 babies were admitted from the post-natal ward with low blood sugars and were promptly escalated to the neonatal team for review and management. 1 case was an appropriate admission, the other however was considered by the MDT to have been avoidable due to admitted at 23 hours for neonatal hypoglycaemia despite glucogel, required NGT feeds - not given in PNW due to lack of transitional care provision for NGT feeds - did not need IVI or NGT and was bottle fed on NNU.

3.3 Neonatal Jaundice

5 babies were admitted to the neonatal unit for treatment of jaundice in quarter 3, 3 were reviewed to be avoidable admissions. 2 of these babies were admitted for this treatment due to lack of capacity within Post Natal ward and Childrens Assessment Unit (CAU)
3 were vaginal births. 2 were C-Section delivery. 4 babies were admitted form the post-natal ward, 1 from community.
The babies were commenced on phototherapy treatment and screened for infection.

3.4 Infection

7 babies were admitted to the neonatal unit with suspected infection this quarter. 6 of these admissions were deemed to have been unavoidable, 1 avoidable admission was monitoring of sugars and missed 2 hours check with failure to follow guideline for NEWTS. Babies were all discharged to postnatal ward well with an average stay on NNU of 28 hours.

3.5 Gastrointestinal disorders

In quarter 3 2023, 1 baby was admitted to the neonatal unit with prolonged vomiting at 38 hours old suspected gastrointestinal disorder. It was deemed to have been unavoidable admission discharged to postnatal ward.

3.6 Other admissions

There were 6 admissions that are not covered by four key clinical areas identified nationally of which 3 were deemed avoidable. The main theme for these was lack of provision for Transitional care facility to support NG tube feeding and syringe feeding following weight loss.

4.0 Challenges to the ATAIN process

There had been previous challenges to maintain quoracy in the ATAIN meetings this is well established now with regular representation from Obstetrics, Neonatology, Maternity, and the Governance team. Clinicians are attending on a rotational basis, with specific dates provided for all staff and a reminder sent out by the Governance team 1 week before the meeting. We are currently undertaking timely and contemporaneous reviews.

A structured and robust process is in place to ensure that the MDT ATAIN reviews can be completed within a 14-day turnaround of incidents occurring. This allows for immediate learning from these incidents to be disseminated to all staff.

Plan for Q4 2023/2024

1. Continue two-weekly MDT meetings to review all eligible cases. These meetings will now be reviewing the most recent term admissions to the NNU.
2. Ensure failsafe processes are in place to confirm all eligible cases are captured for review.
3. Share learning from ATAIN reviews with all staff.
4. To monitor and review more closely the babies admitted with respiratory conditions and/or infection with a view to establish if admission to the neonatal unit can be avoided by alternative methods of treatment.
5. To present the report to Maternity and Neonatal Governance meetings.
6. To an action tracker and to review this regularly at ATAIN meetings.

APPENDIX 3

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance – January 24

Agenda item				
Report	**Transitional Care Audit Q3 Report**			
Executive Lead	**Hayley Flavell 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	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information	√		
	For consent			
Presented to:	Maternity Governance – January 2024			
Dependent upon:	NA			
Executive summary:	This paper is to provide assurance that transitional care is audited in line with the standards as directed by BAPM and reflected in the maternity guideline. In line with the CNST maternity incentive scheme safety point three this paper supports the process of auditing Transitional Care Services. The Transitional Care audit was completed for Q3 using electronic Badgernet records only from October – December 2023. The main findings of this report are: • 84 % babies admitted had daily reviews by the neonatal team. • 100% of Newborn and Infant Physical Examination (NIPE) were completed with 72 hours of birth by the appropriate person. • 3 NIPE examinations were not documented on BadgerNet, but they were documented appropriately on NIPE Smart. • The main reason for admission to Transitional care was suspected infection (79%) and prematurity (19%) . • 83 % had observations inline with guidance. • Appropriate management of thermoregulation if needed.			
Appendices	Data Collection Analysis			

1.0 Introduction

The philosophy of transitional care is to keep mothers and babies together, mothers become the primary care provider for their babies with care requirements in excess of normal newborn care but do not require admission in a neonatal unit and ensures a smooth transition to discharge home.

Transitional care is not a place but a service and this can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting.

Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

2.0 Data Collection

The monthly transitional care audit will be in line with the standards set out in the

guideline: Reason for admission to Transitional care
Reason Recorded and appropriate as guidance
Observations and investigations as guidance and documented appropriately The use of green discharge proforma
Daily neonatal team review
Appropriate NIPE examination
Outcomes

This audit was taken on a random selection based on the monthly transitional care audit of 8 transitional care babies per month totaling 24 babies audits over a quarter which is approximately 20-25 % of babies who are admitted under the transitional care pathway, recommendations will be shared on a quarterly basis to the Director of Midwifery, Divisional Director of Nursing, Maternity and Neonatal Governance teams and the Neonatal Triumvirate.

3.0 Findings

84% babies admitted to Transitional Care were seen daily by the neonatal team with a clearly documented plan of care (Appendix 1).

The NIPE was completed in the correct timeframe by the appropriate person, however this was not correctly documented on Badgernet on 3 occasions and was only documented on NIPE Smart.

83% of the notes audited had observations in line with local guidance. The 17% not completed in line with local guidance were delayed however they were completed within 1-2 hours of the observations being due. From the clinical narrative there were no adverse outcomes or changes to management in the babies whose observations were delayed.

All babies had a completed neonatal discharge summary on badgernet.

4.0 Conclusion

Monthly audits must continue to monitor and escalate any concerns with observation frequency whilst babies are in TC, this will identify any training needs or themes.

Communication will be shared with the maternity and neonatal teams undertaking the NIPE examination to ensure they are on Badgernet and NIPE Smart.

Postnatal baby management plans should be in line with local guidance and visible on Badgernet to support in timely observations.

Action Plan
A robust action plan has been developed.

Action	Action owner	Date
Monthly Audits to continue to monitor and escalate concerns	Neonatal Lead	ongoing
Communication to Neonatal team to remind about documenting NIPE on badgernet	Sarah Whitehead	16.01.24
Reminder at safety huddle and ward meetings about NEWTT observations to ensure they are complete at appropriate time	Ward Managers	Email sent to team 16.01.24 To be discussed at ward meeting Feb 24. Laminated NEWTT frequency chart put by computer – 16.01.24

Appendix 1 – Data Collection analysis

Reason For Admission To TC from birth	Number	Percentage
Babies receiving IVAB	18	75%
Babies at risk of Neonatal Abstinence Syndrome	0	0%
Congenital Anomaly	0	0%
Low birth weight	0	0.00%
Preterm	6	25%
Reason For Admission to TC from NNU	**Number**	**Percentage**
Step down care' following admission from NNU who is more than 1.6kgs and maintaining temperature	0	0.00%
step down care' tolerating a minimum of three hourly feeds	0	0%

	Reason Recorded	Hospital Notes	Obs in line with GL	Green Proforma	NIPE	Seen Daily
Yes	24	0	20	24	24	24
No	0	0	4	0	0	0
Total Percentage - Yes	100%	0	83 %	100%	100%	100 %
Total Percentage - No	0%	0%	17%	0%	0%	0%

APPENDIX 4

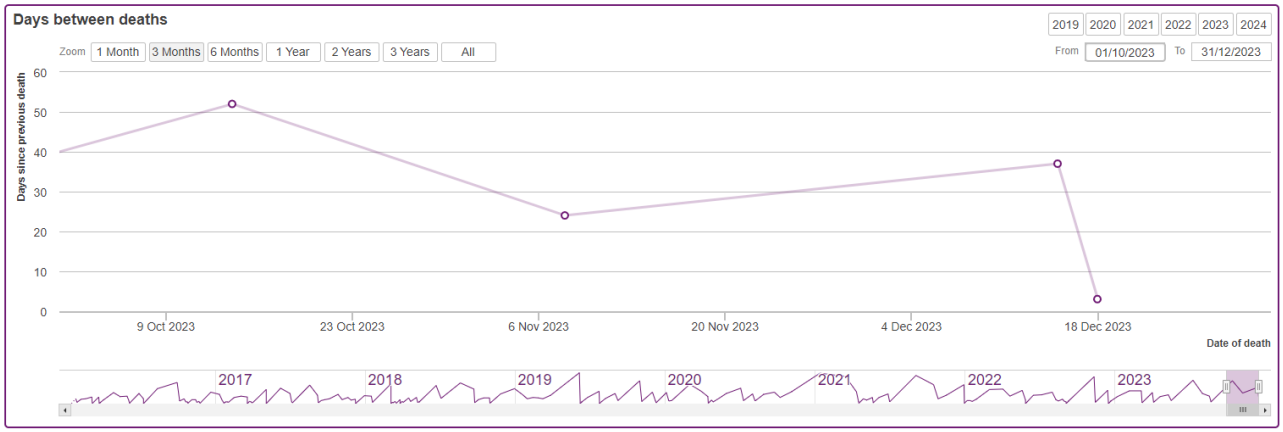
The Shrewsbury and Telford Hospital NHS Trust

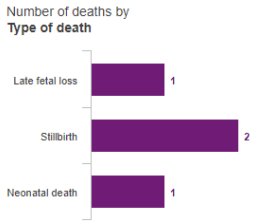
Maternity Governance Meeting
January 2024

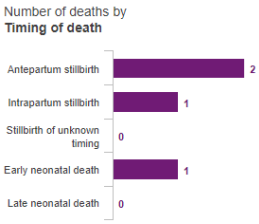
Agenda item				
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report Q3			
Executive Lead	Hayley Flavell			
Report Author	Lesley Stokes			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
	For consent			
Presented to:	Maternity Governance January 2024			
Executive summary:	There were 2 stillbirths, 1 late fetal loss and 1 neonatal death that fitted the criteria for review using PMRT. External Obstetric Consultants have been present at each review of care. Compliance with CNST Safety Action 1 is confirmed in this report.			
Appendices	MBRRACE generated Trust Board Report			
Executive Lead	Hayley Flavell			

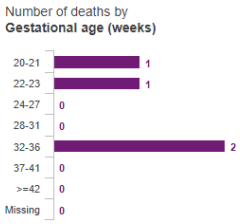
1.0 Deaths reported to MBRRACE

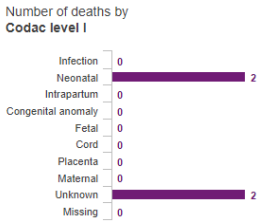
In the time period from the 1st October to the 31st December 2023 there were 2 still births, 1 late fetal loss and 1 neonatal death.











Stillbirths

Stillbirth 1: **90305/1**– PMRT review took place on the 21st of December 2023. Intrauterine Death (IUD) was confirmed at 35 weeks and 1 day. Care issues identified during the review were that the mother did not receive specialist periconceptional counselling/management of her diabetes. This is a service that SATH does not provide and has been escalated to the Divisional Operations Management team. All other aspects of care were deemed appropriate. The grading of care agreed as A – no issues identified.

Stillbirth 2: **90933/1** –Attended planned departmental scan where IUD was diagnosed at 32+5, fetus known to have severe growth restriction and multiple congenital abnormalities. Birth weight of 253grams, PMRT review planned for the 17th of January 2024.

Late Fetal Loss

There was 1 Late Fetal Loss in Quarter 3.

89929/1: PMRT review took place on 21st December 2023. Care issues identified are that there is no evidence that the mother was asked about domestic abuse at booking, the baby had to be transferred elsewhere for the post-mortem and the mother had an indication for 4 hourly observations overnight that were not completed. The grading of care was agreed as a B – care factors identified that would not have made a difference to the outcome.

Neonatal Deaths

There was 1 Neonatal death for Quarter 3.

89833/1: Baby was born before arrival at 27 weeks gestation. Both mother and baby were initially treated at SATH however, the baby was transferred out to New Cross Hospital where he sadly died. This is a complex case as it has been reported by SATH as a Serious Incident. It has had a review by the Infection Prevention Team at SATH and is awaiting a joint PMRT review. Provisional date for the PMRT review is the 22nd of January 2024.

2.0 Safety Action 1 Compliance: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

(Y5 Relaunch) All eligible perinatal deaths should be notified to MBRRACE-UK within 7 working days. For deaths from 30th May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.

In Quarter 3, (Oct, Nov and Dec 2023) there were there were 2 stillbirths, 1 late fetal loss and 1 neonatal death that fitted the criteria for review using PMRT. These cases were reported to MBRRACE within the specified timeframe.

Quarter 3	Notified to MBRRACE	Surveillance information completed
Still birth: 90305/1	Yes	Reported to MBRRACE within 2 days of loss. Case reviewed within 6 weeks of being reported. Report completed within 2 months of being reported.
Still birth: 90933/1	Yes	Reported to MBRRACE on the day of loss. Case planned to be reviewed within 4 weeks of loss (planned for the 17.1.24).
Late fetal loss: 89929/1	Yes	Reported to MBRRACE within 3 days of loss. Case reviewed within 6 weeks of being reported. Report completed within 3 months of being reported.
Neonatal death: 89833/1	Yes	Reported to MBRRACE by New Cross Hospital who are leading with this process. Joint review planned for the 22.1.24.

(Y5 Relaunch) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30th May 2023 onwards.

Quarter 3	Families informed	Source
Still birth: 90305/1	Yes	Bereavement midwives
Still birth: 90933/1	Yes	Bereavement midwives
Late fetal loss: 89929/1	Yes	Bereavement midwives
Neonatal death: 89833/1	Yes	New Cross Hospital

(Y5 Relaunch) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using PMRT should be carried out from 30th May 2023. 95% of reviews should be started within two months of the death and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

Quarter 3	Review started	Draft report stage	Published report
Stillbirth: 90305/1	21.12.23	21.12.23	Planned publish date of the 5.1.24
Stillbirth: 90933/1	Planned date of the 17.1.24	N/A	N/A
Late fetal loss: 89929/1	21.12.23	21.12.24	Planned publish date of the 5.1.24
Neonatal death: 89833/1	Coordinated by New Cross Hospital		

Each case reported in Quarter 3 has been reviewed and is on track to meet the criteria targets.

(Y5 Relaunch) Quarterly reports will have been submitted to the Trust Executive Board from 30th May 2023.

Quarter 3 report will be presented to Maternity Governance on the 19th January 2024 and on to the Maternity Safety Champions and Trust Executive Board following acceptance.

3.0 Conclusion

3.1 Compliance has been met with the CNST safety action 1 requirements, and this report concludes and provides evidence that the National Perinatal Mortality Review Tool is being used to review perinatal deaths to the required standard in Quarter 3.

Author name and title
Lesley Stokes
Risk Manager – Childrens Centre
Quality Governance Team
Date 04/01/2024

Appendix 1: MBRRACE Generated Trust Board Report

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

The Shrewsbury and Telford Hospital NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/10/2023 to 31/12/2023

There are no published reviews for The Shrewsbury and Telford Hospital NHS Trust in the period from 1/10/2023 to 31/12/2023

Report Generated by: Michelle Powell
Date report generated: 16/01/2024

APPENDIX 5

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting
February 2024

Agenda item				
Report Title	ATAIN Avoiding Term Admissions into Neonatal Units Action Plan 2024			
Executive Lead	Hayley Flavell			
Report Author	Jo Kench - Children's Incident Lead Jasmin Smith - Intrapartum Matron & Triage Matron Paula Pryce – Fetal Monitoring Lead Midwife			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	
	Our service delivery		Caring	
	Our governance	√	Responsive	
	Our partners		Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
	For consent			
Presented to:	**Maternity and Neonatal Governance Meetings**			
Executive summary:	This paper summarises the work undertaken by the Maternity and Neonatal teams at the Shrewsbury and Telford Hospital Trust (SaTH), to reduce the number of term infants admitted to the neonatal unit in line with ATAIN. The report purpose is to note the progress made from the 2023 action plan and to confirm the action plan for 2024 based on the findings of the quarterly ATAIN reports.			
Executive Lead	Hayley Flavell, Director of Nursing			

Background

In 2017, NHS England identified that over 20% of admissions of full-term babies to neonatal units could be avoided. By providing services and staffing models that keep mother and baby together we can reduce the harm caused by separation.

Admission to a neonatal unit can lead to unnecessary separation of mother and baby. There is overwhelming evidence that separating mother and baby at or soon after birth can affect the positive development of the mother-child attachment process and adversely affect maternal perinatal mental health.
Preventing separation except for compelling medical indications is essential in providing safe maternity services.

The ATAIN programme was widely introduced in 2018, and forms part of what is now. known as the Maternity and Neonatal Safety Improvement programme (MatNeoSIP)

NHS providers of maternal and neonatal care can use data collected through ATAIN reviews as a resource to:

- To improve the safety of care.
- To keep mothers and babies together when it is safe to do so.
- To identify local improvement priorities.
- To develop an action plan to ensure any relevant resources are introduced into clinical practice.

Improving the safety of maternity services is a key priority for the NHS and the number of unexpected admissions of full-term babies (i.e., those born at 37 weeks or more), is seen as a proxy indicator that harm may have been caused at some point along the maternity or neonatal pathway.

ATAIN focuses on four key clinical areas that represent a significant amount of potentially avoidable harm to babies:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischemia)

Previously the 2023 Annual Atain report highlighted several actions for the Trust to deliver. The below Action plan highlights the key areas for the trust to focus on.

ATAIN Action Plan 2023

1. Scheduled MDT meetings to continue, reviewing all term admissions to the neonatal unit, identifying where avoidable admissions occur, creating action plans as required and sharing the learning widely with staff.
2. To ensure failsafe processes are in place to confirm all eligible cases are captured for review.
3. To establish pathways for phototherapy in community settings.
4. To monitor and review the babies admitted with respiratory conditions and/or infection with a view to establish if admission to the neonatal unit can be avoided by alternative methods of treatment.

5. To present the quarterly report and any associated action plans via the divisional governance processes.

The below demonstrates the progress of the 2023 Action plan.

Progress of 2023 Action Plan

1. Fortnightly MDT meetings continue with both Obstetricians & Neonatologists, Fetal Monitoring Lead Midwife &Senior Midwifery team reviewing all term admissions to NNU and identifying those which could have been avoided. Action plans are created to include when there is Shared learning and good practice.
2. Failsafe process continues to confirm all eligible cases and ensure timely review. The Red book located in Neonatal Unit & Badgernet crossed referenced to give assurance.
3. Community Phototherapy pathway. Ongoing work continues to develop the service.
4. Comprehensive reviews undertaken to review Antenatal and intrapartum care to identify if interventions should have been undertaken earlier to avoid admission.
5. Quarterly reports and any associated action plans are presented at both divisional and speciality governance meetings.

Quarterly Data - Q4 2022/23 Q1-Q3 2023/24

Quarter 4 Metrics (January, February, March 2023)

The term admission rate for Q4 (Jan, Feb, Mar 2023) was 5.3% of all births at >37 weeks. This is below the national target of 6% and remains unchanged from quarter 3.

A total of 46 term babies were admitted to the Neonatal Unit in Q4 2023 (comparing with 46 in the previous quarter.) There was 1 avoidable admission.

The numbers of babies admitted each month were:

Jan 2023 – 6.3% of all births at >37 weeks (n = 18)

Feb 2023 – 4.6% of all births at >37 weeks (n = 13)

Mar 2023 – 4.7% of all births at >37 weeks (n = 15)

Reason for admission	**Number of babies > 37/40**
Respiratory conditions	20
Infection	9
Hypoglycaemia	4
Gastrointestinal disorders	3
Jaundice	4
Observations	6
Babies who were transferred out for therapeutic hypothermia	0
Total	46

Avoidable Admission for Quarter 4

Neonate delivered 40+6 weeks gestation, was admitted to Neonatal Unit at 1hour old. The Neonate had a Vaginal Birth and was admitted from Labour Ward. The primary reason for admission was Respiratory Distress. After extensive review at the ATAIN meeting it was decided that this was an avoidable admission. The reason way it was avoidable was due to the Cardiotocgraphy (CTG) being removed in labour due to the patients request as she was in pain. As the CTG was removed the fetal wellbeing was not being monitored appropriately. It was documented that the patient was contracting rapidly and once this was identified the CTG was recommenced with patient consent resulting in a rapid birth which contributed to the respiratory distress.

Quarter 1 Metrics (April, May, June 2023)

The term admission rate for Q1 (April, May June 2023) was 5.0% of all births at >37 weeks, a slight reduction from the previous Q4 figure of 5.3%. The year-to-date term admission rate is 5.0%. This rate remains below the national target of 6%.

A total of 45 term babies were admitted to the Neonatal Unit in Q1 2023 (comparing with 46 in the previous quarter.) There was 1 avoidable case in April 2023, 2 cases in May 2023, and 2 cases in June 2023.

The numbers of babies admitted each month were:

April 2023 – 3.7% of all births at >37 weeks (n = 11)

May 2023 – 6.3% of all births at >37 weeks (n = 18)

June 2023 – 5.1% of all births at >37 weeks (n = 16)

This is a table which provides reasons for admission to Neonatal Unit

Reason for admission	Number of babies > 37/40
Respiratory conditions	23
Infection	9
Neonatal Abstinence Syndrome	1
Hypoglycaemia	3
Gastrointestinal disorders	3
Jaundice	2
Observations (inc. Failed oximetry)	2
Congenital abnormality	1
Social reasons	1
Babies who were transferred out for therapeutic hypothermia	0
Total	45

Avoidable Admission for Quarter 1

Case 1 – April

The neonate delivered at 42+6 weeks gestation and was admitted to the neonatal Unit at 1 hour old. The neonate delivered by emergency caesarean section and the primary reason for admission was respiratory distress. Following the ATAIN review meeting this case was identified as avoidable due to inappropriate admission. The Neonate was transferred as requiring Oxygen, however when reviewed by the registrar oxygen requirement was not necessary.

Case 2 – May

The neonate delivered at 39+0 weeks gestation and was admitted to Neonatal Unit at 1 hour old. The neonate had an elective caesarean section and was admitted from Labour Ward. The primary reason for admission was Respiratory Distress. This case was an avoidable admission due to human error. The resuscitaire had not been turned on correctly resulting in no oxygen being available, therefore when the neonate required oxygen this resulted in low saturations and immediate transfer.

Case 3 – May

The neonate delivered at 38+4 weeks gestation and was admitted to neonatal Unit at 1 hour old. The neonate had an elective caesarean section and was admitted from Labour Ward. The primary reason for admission was respiratory distress. This case was an avoidable admission due to human error. There was no documentation of resuscitation at birth. It was also noted that there was no oxygen cylinder was empty.

Case 4 – June

The neonate delivered at 38+3 weeks gestation and was admitted to neonatal unit at 6 hours old. The neonate had a vaginal delivery and was admitted from Labour Ward. The primary reason for admission was hypothermia. This case was an avoidable admission due to lack of inappropriate management of hypothermia as there was no evidence of neonate temperature being recorded documented prior admission to the neonatal unit.

Case 5 – June

The neonate delivered at 40+2 weeks gestation and was admitted to neonatal unit at 5 hours old. The neonate was delivered by an emergency caesarean section, the primary reason for admission was respiratory distress. Following the ATAIN review meeting this case was identified as avoidable due to delayed induction and prolonged labour, if intervened sooner this may have prevented this admission.

Quarter 2 Metrics (July, August, September 2023)

The term admission rate for Q2 (July, August, September 2023) was 6.0% of all births at >37 weeks, a slight increase from the previous Q1 figure of 5.0%. The year-to-date term admission rate is 5.0%. This rate remains below the national target of 6%.

A total of 58 term babies were admitted to the NNU in Q2 2023 (comparing with 45 in the previous quarter.) There was 0 avoidable case in July 2023, 4 cases in August 2023, 0 cases in September 2023.

The numbers of babies admitted each month were:

July 2023 – 5.4% of all births at >37 weeks (n = 17)

August 2023 – 6.0% of all births at >37 weeks (n = 21)

September 2023 - 7.0% of all births at >37 weeks (n = 20)

This table provides the reasons for admission to neonatal unit.

Reason for admission	Total Q2 - Number of babies > 37/40
Respiratory conditions	37
Infection	8
Neonatal Abstinence Syndrome	0
Hypoglycaemia	5
Gastrointestinal disorders	2
Jaundice	5
Observations (inc. Failed oximetry)	2
Congenital abnormality	0
Babies who were transferred out for therapeutic hypothermia	2
Total	58

Avoidable Admissions Quarter 2

Case 1 August

The neonate delivered at 38+3 weeks gestation and was admitted to neonatal unit at 1 hour old. The neonate delivered by elective caesarean section and the primary reason for admission was respiratory distress. Following the ATAIN review meeting this case was identified as avoidable admission due to the gestation at delivery. It was agreed at ATAIN that the neonate should have been delivered 7 days later at 39 weeks as per guidance.

Case 2 August

The neonate delivered at 39+1 weeks gestation and was admitted to neonatal Unit at 1 hour old. The neonate delivered by elective caesarean section from Labour ward. The primary reason for admission was respiratory distress. Following review this case was

identified as an avoidable admission due to lack of Midwifery observations for the first feed following birth.

Case 3 August

The neonate delivered at 38+6 weeks gestation and was admitted to neonatal unit at 6 hours old. The neonate was delivered vaginally and as admitted from Labour ward. The primary reason for admission was poor feeding and hypothermia. Following review this case was identified as avoidable due to ineffective warming on Maternity. To ensure effective warming neonate should only wear a nappy.

Case 4 August

The neonate delivered at 38+3 weeks gestation and was admitted to neonatal unit less than 30 minutes old. The neonate delivered by Neville barnes forceps and was admitted from labour ward. The primary reason for admission was Hypoxic-Ischemic Injury (HIE), requiring therapeutic cooling. Following the ATAIN review the case was identified as avoidable due to sub optimal CTG.

Quarter 3 Metrics (October, November, December)

The term admission rate for Q3 (Oct, Nov, Dec 2023) was 6.5% of all births at >37 weeks, an increase from the previous Q2 figure of 6.0%. The year-to-date term admission rate is 5.6%. This rate is at the national target of 6.0%.

A total of 62 term babies were admitted to the NNU in Q3 2023 (comparing with 57 in the previous quarter.) There were 6 avoidable cases in October 2023, 4 cases in November 2023 and 2 cases in December 2023.

The numbers of babies admitted each month were:

Oct 2023 7.0% of all births at >37 weeks (n = 23)

Nov 2023 7.4 % of all births at >37 weeks (n = 25)

Dec 2023 4.7% of all births at >37 weeks (n = 14).

This table provides the reasons for admission to neonatal unit.

Reason for admission	Number of babies > 37/40
Respiratory conditions	40
Infection	7
Hypoglycaemia	2
Jaundice	5
Gastrointestinal disorders	0
Babies transferred out for therapeutic hypothermia	2
lack of provision for Transitional Care support	6
Total	62

Avoidable Admissions Quarter 3

Case 1 October

The neonate delivered at 37+2 weeks gestation and was admitted to neonatal unit at 72 hours old. The neonate delivered vaginally and was admitted to the neonatal unit from the postnatal ward. The primary reason for admission was jaundice. Following review this case was identified as avoidable admission due to Laboratory error. The result was reported incorrectly.

Case 2 October

The neonate delivered at 42 weeks gestation and was admitted to neonatal unit at 7 hours old. The neonate delivered vaginally and was admitted to the neonatal unit from the postnatal ward. The primary reason for admission was respiratory distress. Following a review this case was identified as avoidable admission due to no transitional care nurses on postnatal ward.

Case 3 October

The neonate delivered at 39+5 weeks gestation and was admitted to neonatal Unit at 23 hours old. The neonate delivered vaginally and was admitted to the neonatal unit from postnatal ward. The primary reason for admission was hypoglycaemia. Following review this case was identified as avoidable admission due to no transitional care nurses on postnatal ward to support Nasogastric feeding.

Case 4 October

The neonate delivered at 40+3 weeks gestation and was admitted to Neonatal Unit at 1 hour old. The neonate delivered by Neville Barnes forceps and was admitted to the neonatal unit from labour ward. The primary reason for admission was respiratory distress. Following review this case was identified as avoidable admission due to sub optimal CTG in labour and earlier intervention could have prevented admission.

Case 5 October

The neonate delivered at 38+6 weeks gestation and was admitted to neonatal unit at 4 hours old. The neonate delivered by elective caesarean section from labour ward. The primary reason for admission was respiratory distress. Following review this case was identified as avoidable admission due to gestation at delivery. Investigating further there was no evidence of steroids being offered to assist with early delivery which could have prevented admission.

Case 6 & 7 November

The neonates delivered at 37+5 weeks and 38 weeks respectively gestation and both were admitted to neonatal unit from home. The primary reason for admission for both cases were jaundice. Following review at ATAIN it was decided that both cases were avoidable admissions due to no capacity on the postnatal ward, therefore as a place of safety the neonates were admitted to the Neonatal Unit.

Case 8 November

The neonate delivered at 38 weeks gestation and was admitted to neonatal unit at 30 hours old. The neonate delivered by an emergency caesarean section and was admitted

to the neonatal unit from postnatal ward. The primary reason for admission was Hypothermia. Following review this case was identified as avoidable admission due to lack of monitoring the neonates' temperature prior to transfer from delivery suite.

The remaining 3 cases were all avoidable admissions to the Neonatal Unit due to lack of trained nurses to support nasogastric feeding when neonates are reluctant feeders.

Conclusion

The rate of admission of term infants to the neonatal unit at SaTH remains below the national target. The neonatal and maternity team continue to work to maintain this standard by implementing learning from the reviews and adopting best practice in care pathways to avoid unnecessary separation of mother and baby.

The Shrewsbury and Telford Hospital NHS Trust

Action Plan ATAIN (Avoiding Term Admission in Neonates) 2024 Plan

Action Plan ATAIN 2024 Plan	**Date**	31/01/2024

Areas for Review	Recommendation/ Action	Lead Person	Target Date for completion	Progress of actions	Date of completion
Low Average temperature in Delivery Suite rooms 23 degrees	Temperatures to be completed daily in every room, theatre and recovery. Coordinator to have oversight of checking	Intrapartum Matron	February 2024	Temperature sheets checked for month of November Poor compliance noted. Added to huddle and Band 7 meeting	
	Estates contacted on 3.12.2023 to increase temperature on delivery suite	Intrapartum Matron	December 2023	Estates contacted December 2023. Temp checks daily	December 2023
On transfer to Neonatal Unit Babies temperature not being documented	Babies Temperature to be completed on discharge/transfer and documented on badger	Intrapartum Matron	January 2024	No current guidance To be added to huddle Emailed digital midwife to ask if this can be mandatory question. January 2024 Added to huddle, to remain on huddle for 1 month.	

				Unable to make mandatory question on badger	
NLS trained professional to attend resus	All Delivery Suite/Triage Coordinators to be NLS trained to ensure the delivery suite is appropriately covered with a NLS instructor.	Intrapartum Matron	March 2024	All delivery suite and triage coordinators are either training or booked onto NLS.	
Patients did not have NEWITT as per guidance	Attain board to be created on delivery suite highlighting who needs NEWTT observations and blood glucose monitoring	Ward Manager	March 2024	Ongoing	
Transitional Care provision	Develop the service to reduce the number of babies being separated from mother admitted to NNU for feeding issues requiring NG and Syringe feeds.	Senior leadership team	On going		
Continue two-weekly MDT meetings	Review all eligible cases. These meetings will now be reviewing the most recent term admissions to the NNU.	Consultant obstetrician Consultant neonatologist Midwifery Matron Governance Lead (Terms of reference)	On going		

Wider Learning from ATAIN reviews to be Shared	Develop a ATAIN specific Learning Gems Poster to be updated monthly with key learning and good practice from both areas of obstetrics & Neonatal	Children's Incident lead W&C Governance Team	March 2024		
Name of Lead for Action Plan:				**Date:**	

APPENDIX 6

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting February 2024

Report	Saving Babies Lives: progress report (amended 23/2/24)			
Executive Lead	Hayley Flavell, 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 15	
	For noting	√		
	For information	√		
	For consent			
Presented to:	Maternity Governance			
Dependent upon	n/a			
Executive summary:	This paper provides an update on the Trust's progress of implementation of the new standards within newest version of SBLCB and an overview of compliance of implemented standards within some of the elements. **Highlights for Q3 2023** Relating to Element 1: • Carbon Monoxide (CO) testing should be offered to all pregnant women at the antenatal booking and 36 week appointment. Take assurance that the stretch ambition of 95% has been maintained over the last quarter for booking. The 36 week appointment point is close to the stretch ambition. • CO monitoring offered at additional antenatal appointments for women who smoke. Take assurance that the minimum target of ≥80% has been meet. • Smoking Status updated each time CO monitoring for smokers – remains compliant Smoking status at 36 weeks for all women - now compliant			

	• **Concern** Smoking in pregnancy/VBA annual training - Medical Staff are currently not compliant with the minimum ambition of ≥80%. Relating to Element 2: • Approved digital BP monitors have been purchased by the Trust • Staff who perform FH measurement should be competent – **concern** as minimum compliance not yet met • All Babies born <10th centile remains below the Perinatal Institutes national GAP user average. • Take assurance that no trends or missed opportunities were identified for undetected <3rd centile babies in Quarter 3 2023. Relating to Element 3: • Take assurance that element 3 (reduced fetal movements) remains fully compliant demonstrated in a recent review Relating to Element 4: • Take assurance of the high compliance of undertaking an initial intrapartum risk assessment. • Take assurance that the compliance for undertaking hourly peer reviews (fresh eyes in high risk intrapartum care) has met the minimum target in February. Relating to Element 5: • Take assurance that the Trust's rolling average of 5.8% for preterm births in 2023 continues to meet the national target of 6% or below of total births. • Total Perinatal Optimisation Pathway Compliance (Composite metric) has met the local stretch ambition. • Note that there are Action Plans within the Preterm report to help improve individual perinatal optimisation compliance ambitions Relating to Element 6: • Note that Intermittent glucose monitoring has now been introduce for Type 2 diabetic women. • Note **concern** that to date the required Diabetic Dietician has not joined the MDT Diabetic (pregnancy) clinic. • Note **concern** that to date we do not have a DKA pathway as specified within SBLCBv3.
Appendices	Additional reports (separate documents) 1. Quarter 3 2023-24 SGA and FGR review 2. Quarter 32023-24 Preterm review
Author	Lindsey Reid Lead Midwife for Saving Babies' Lives and Preterm Prevention The Shrewsbury and Telford Hospital NHS Trust

1.0 Introduction.

1.1 The Saving Babies Lives (SBL) care bundle is designed to reduce perinatal mortality, and its implementation constitutes Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), of which SaTH is a participant.

1.2 The Trust was able to prove full compliance with the requirements of SBL as part of year 3 and year of CNST.

1.3 SaTH is now part-way through delivery of CNST year 5(2023-24), which includes implementation of SBL version 3. The purpose of this paper is to:

1.3.1 Provide updates to the Maternity Governance committee.
1.3.2 Provide quarterly reports of information which require sharing (as per SBLCBv2) with the Trust Board and LMNS.

2.0 Background.

2.1 The first version of the Saving Babies' Lives Care Bundle (SBLCB) was published in March 2016 and focussed predominantly on reducing the stillbirth rate[1]. The care bundle was designed to deliver the then Secretary of State for Health's announced ambition to halve the rates of stillbirths, neonatal and maternal deaths, and intrapartum brain injuries by 2030, with a 20% reduction by 2020. The care bundle consisted of four standards.

2.2 In November 2017, as part of the National Maternity Safety Strategy, the national ambition was extended to include reducing the rate of preterm births from 8% to 6% and the date to achieve the ambition was brought forward to 2025[2]. This is reflected in the NHS Long Term Plan.[3]

2.3 The second version of the care bundle was published in 2019 and included a fifth element: 'Reducing preterm birth'.[4]

2.4 The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020. ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data shows there is more to do to achieve the Ambition in 2025 period (SBLCBv3).

[1] https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf
[3] https://www.longtermplan.nhs.uk/
[4] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

2.5 The 3rd version of the care bundle (SBLCBv3)[5] was released in June of this year. Building on the achievements of the previous versions, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit.

There are now 6 elements of care:

2.5.1 Element 1 Reducing smoking in pregnancy
2.5.2 Element 2 Fetal Growth: Risk assessment, surveillance, and management
2.5.3 Element 3 Raising awareness of reduced fetal movement (RFM)
2.5.4 Element 4 Effective fetal monitoring during labour
2.5.5 Element 5 Reducing preterm birth
2.5.6 Element 6 Management of pre-existing diabetes in pregnancy

2.6 The CNST year 5- Safety action 6 required standard reads

2.6.1 Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

2.6.2 Hold quarterly quality improvement discussions with the ICB, using the national implementation tool.

3.0 The Trust actively participates in engaging with regional and national Trusts and networks developed to share standards, action plans, learning and peer support. Below are the main active groups.

3.1 Regional – NHS England Midlands

- SBLCBv3 Community of Practice (hosted by the Midlands Perinatal Team)
- Midlands Preterm Group (hosted by the Midlands Perinatal Team)- active members participating in developing regional pathways
- Regional Fetal Monitoring group (hosted by the Midlands Perinatal Team)

3.2 National

- SBL forum – support network created for Trusts, currently chaired by SaTH representative
- National Fetal Monitoring network
- Perinatal Institute
- Preterm Midwives Network – linked to UK Preterm Birth Network (represented by SaTH's Preterm Prevention Lead Midwife).
- UK Preterm Birth Network

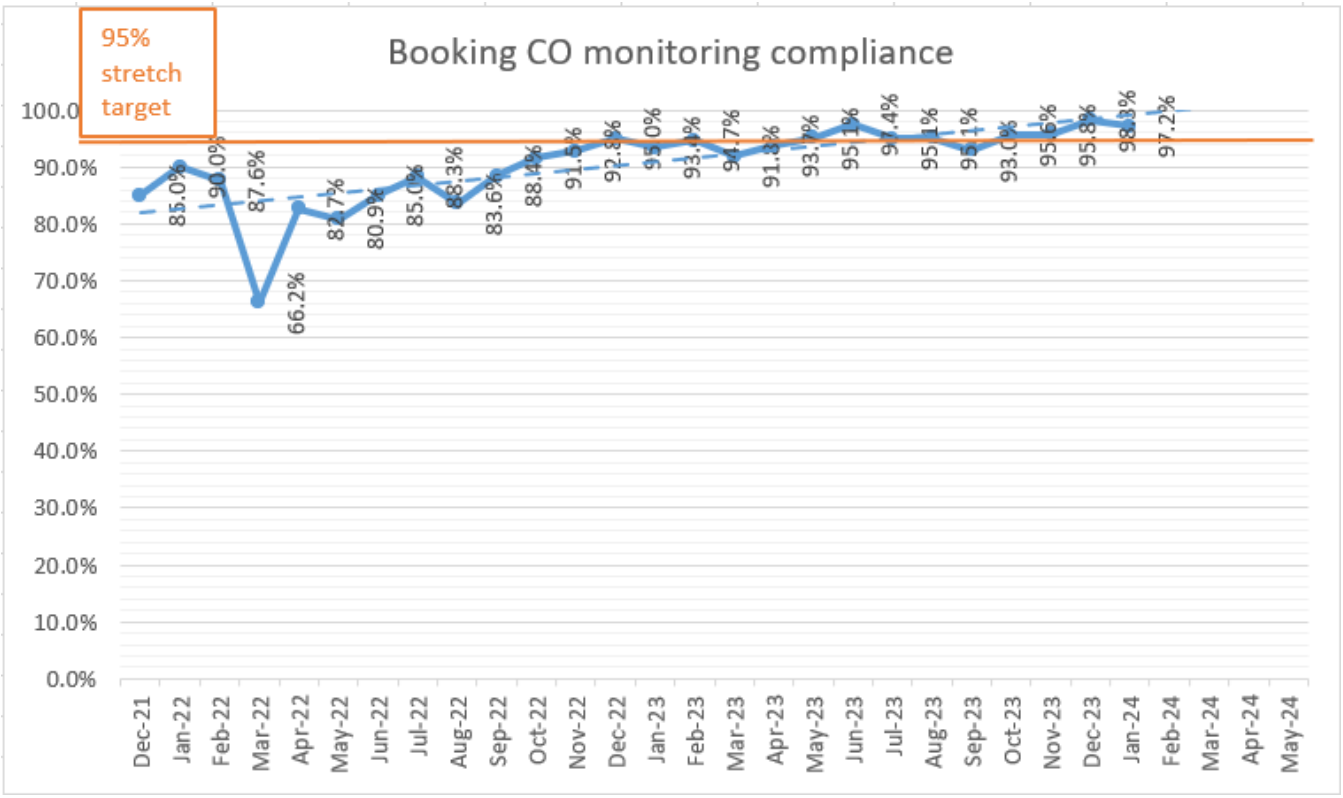
[5] https://www.england.nhs.uk/publication/saving-babies-lives-version-three/

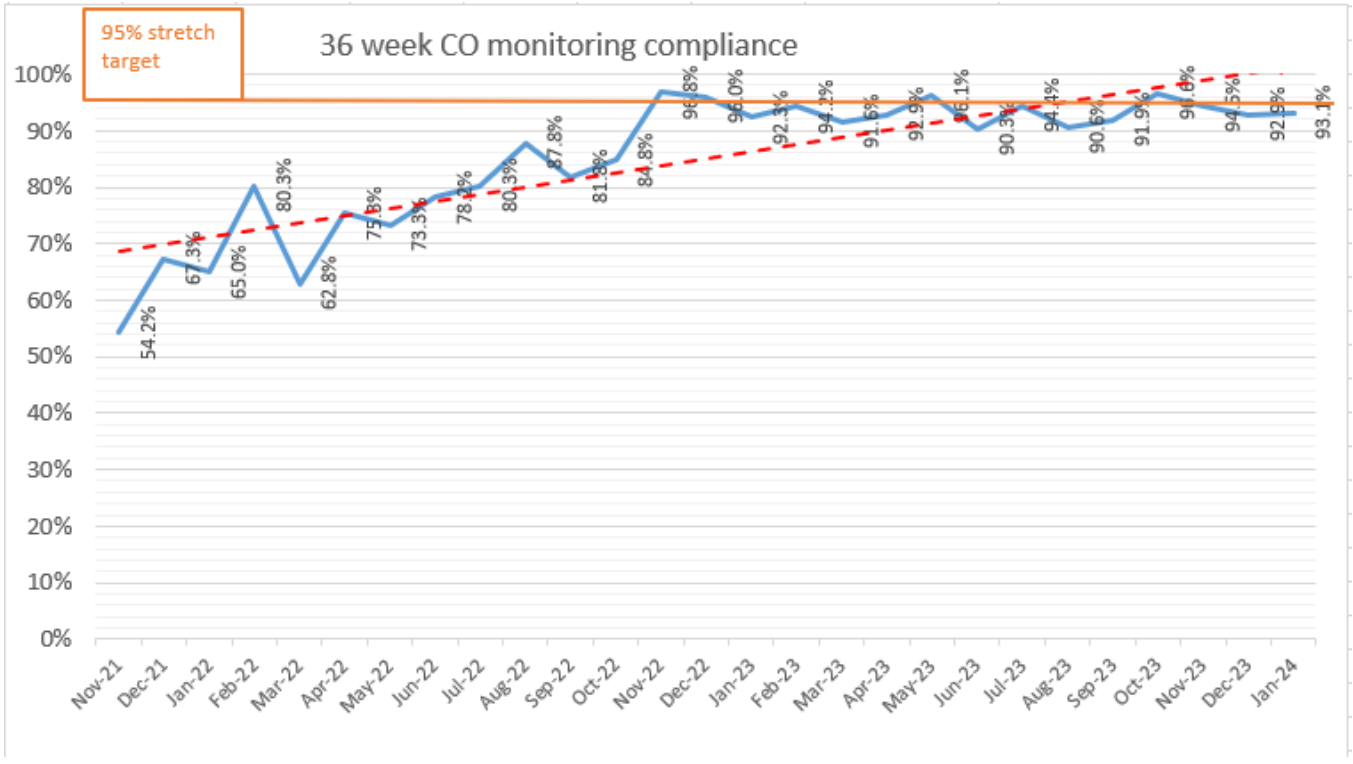
4.0 Progress update on Element 1: Reducing smoking in pregnancy

4.1 SBL/CNST year 5 mandates the following standards:

4.1.1 Carbon Monoxide (CO) testing should be offered to all pregnant women at the antenatal booking and 36 week appointment.

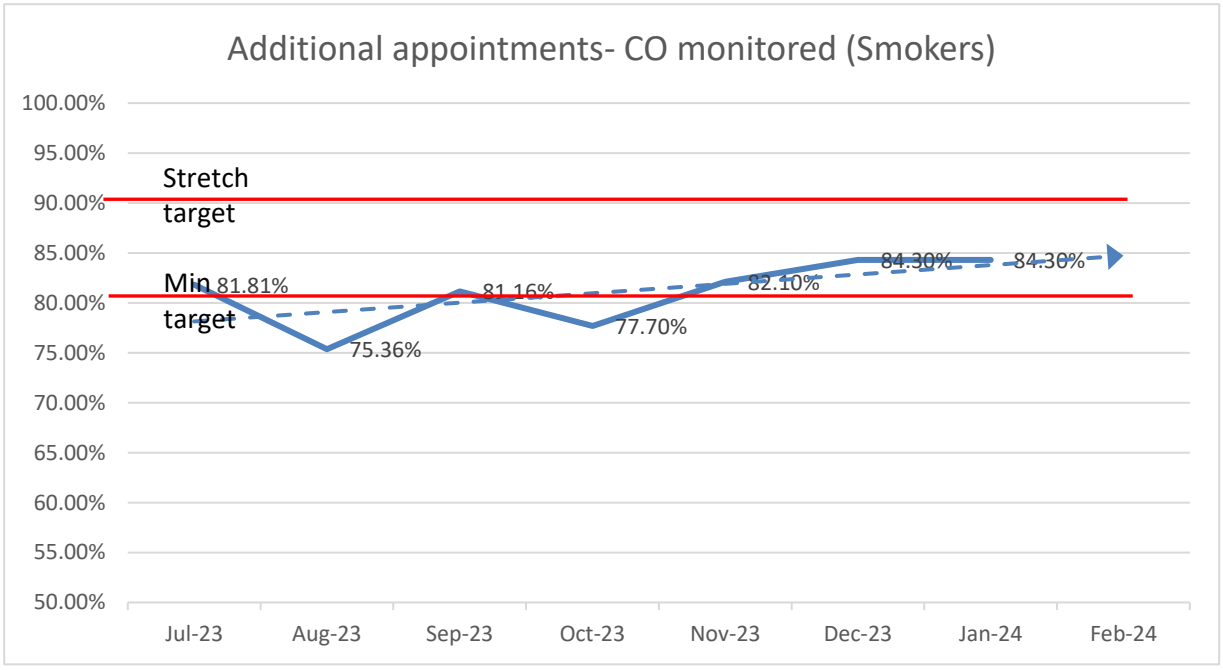
The stretch target of 90% has been maintained over the last quarter for both.





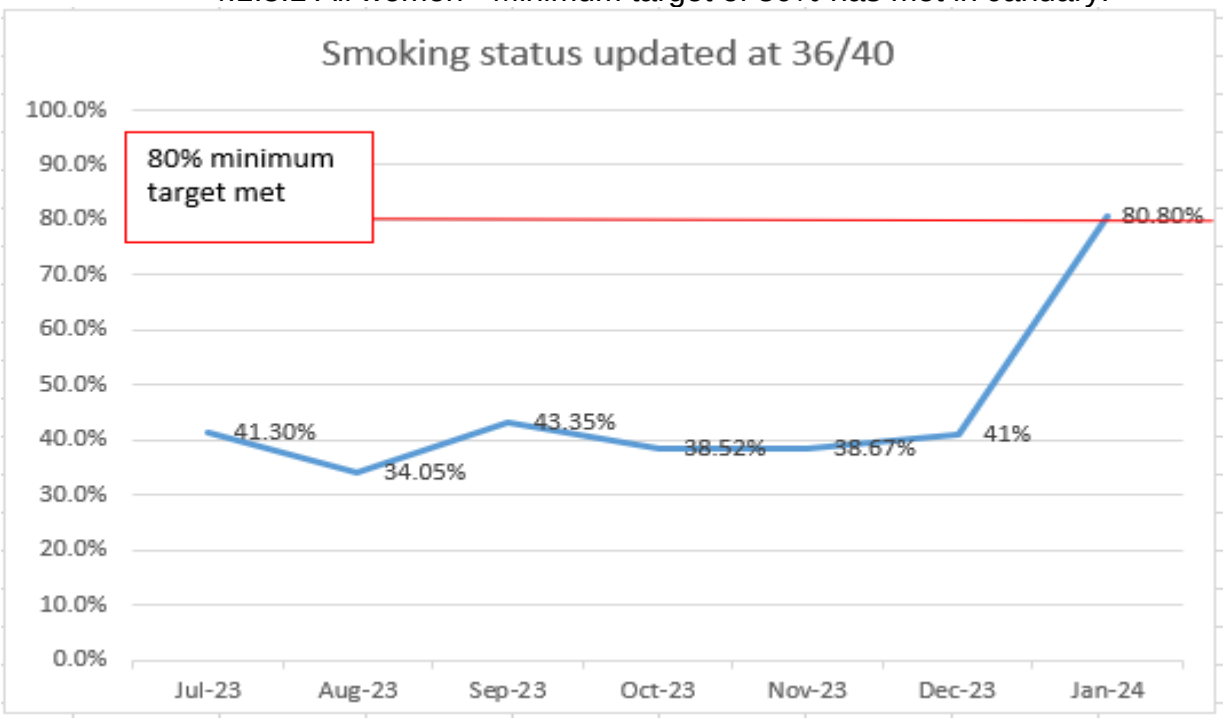
4.1.2 CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209[6] (person that identifies themselves as a smoker).

The minimum locally set ambition of 80% has been achieved over the last 3 consecutive months.



4.1.3 Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded. New standard in version 3

4.1.3.1 All women - Minimum target of 80% has met in January.



[6] https://www.nice.org.uk/guidance/ng209

Action plan for 4.1.4 and 4.1.5

- Continue monitoring monthly
- Cascade results to Managers
- Report quarterly to Maternity Governance
- Report progress to system partners through the SBLCBv3 implementation tool quarterly reviews

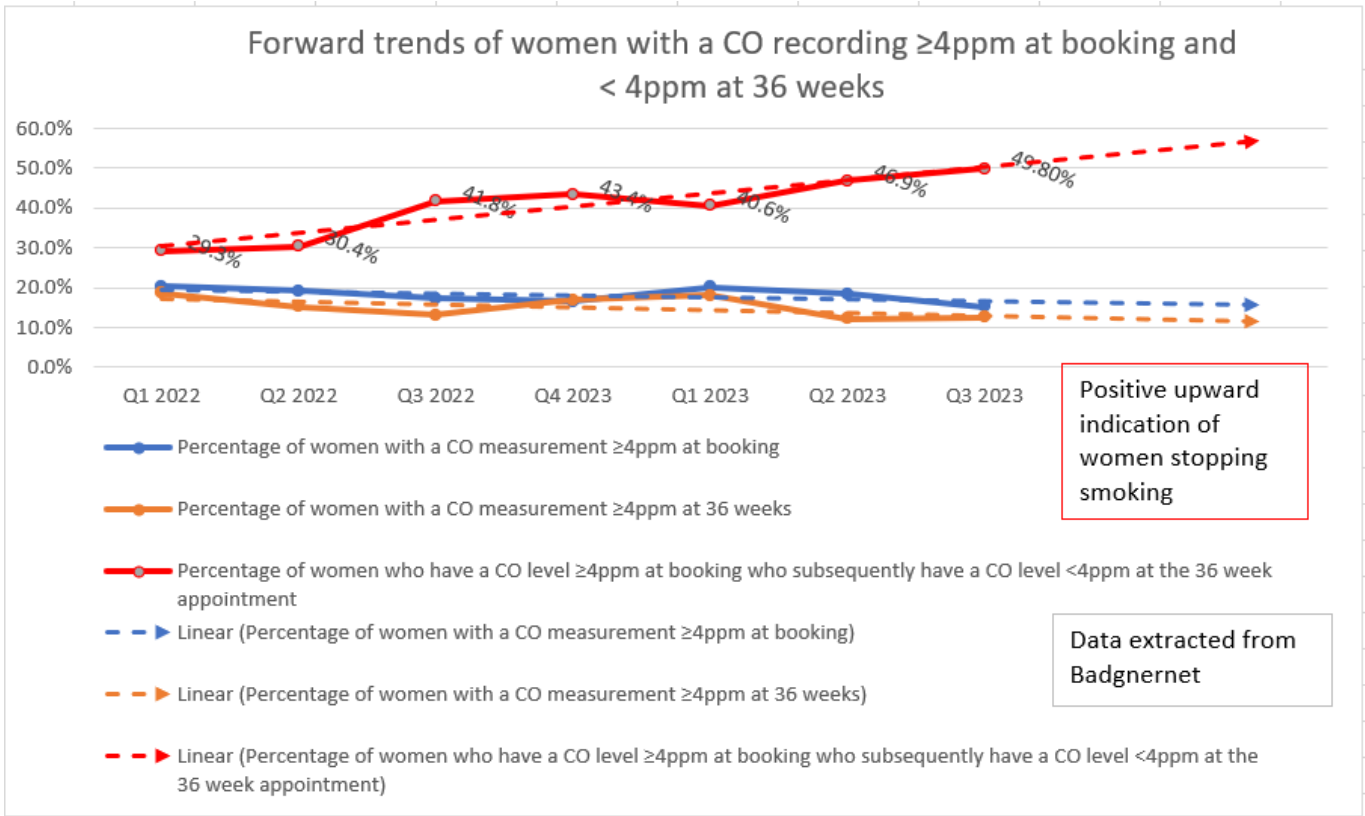
4.1.3.2 Updating smoking status at all CO monitoring's remains compliant with the locally set stretch ambition at 60.2%.

Both are 4.1.3.1 and 4.1.3.2 positive results for this quarter.

4.1.4 The following are outcome indicators for Element 1

i. Percentage of women with a CO measurement ≥4ppm at booking.
ii. Percentage of women with a CO measurement ≥4ppm at 36 weeks.
iii. Percentage of women who have a CO level ≥4ppm at booking and <4ppm at the 36 week appointment.

The following chart demonstrates SaTH's service user data (extracted from Badgernet) and linear forward trends.
NB – although a positive indicator of a reduction in smoking by 36/40, a small proportion will be non-smokers at booking but had a booking CO of ≥4ppm.



4.1.5 SBLCBv3 mandates

All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g., referral, feedback, data collection).

Currently Midwives and Support staff (MSW/WSA) are compliant with the national ambition of ≥ 90%

Medical Staff are currently not compliant with the minimum ambition of ≥80%. **This is a concern**. This has been escalated to the SLT and there is an action plan in place to improve compliance prior to March 2024.

5.0 Update on Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

5.1 SBLCBv3 mandates

As part of the (booking) risk assessment for FGR, blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy

5.1.2 Update on progress

Approved digital BP monitors have been purchased by the Trust and are currently being collected by all areas undertaking bookings.

The following guidelines have been updated accordingly

- Hypertensive Disorders of Pregnancy in the Antenatal, Intrapartum and Postnatal Period v3.4
- Small for Gestational age and Fetal growth restriction Risk assessment, surveillance and management v3.2

5.2 SBLCBv3 mandates

Staff who perform FH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated. Only staff who perform FH measurement need to undergo training in FH measurement.

Due to the change in the TNA/CCFv2 in August 2023, the above competency was changed from once only to 3 yearly. The change made a large proportion of Midwifery and Medical Staff as out of date. As this was not included in the CNST SA 8 (training) for year 5 it has had less focus.

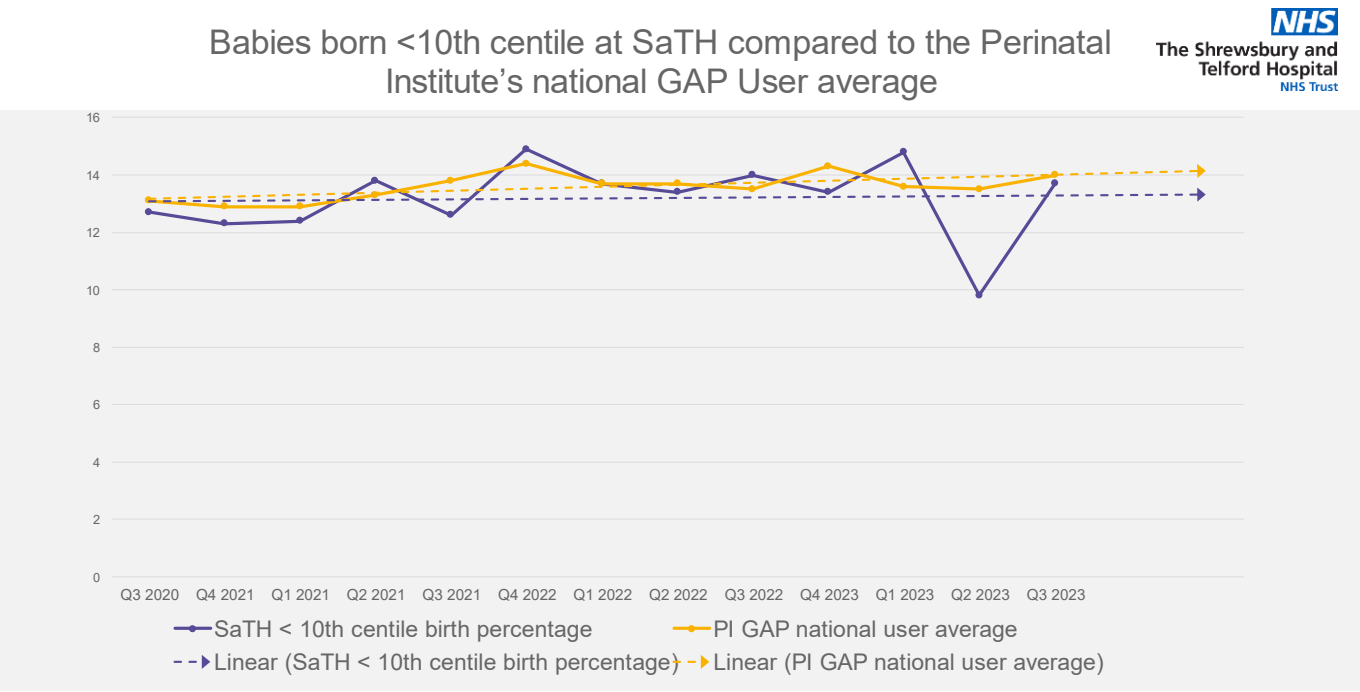
Minimum compliance is set nationally at ≥80% with an action plan to achieve ≥90% reliable.

This is a **current concern** for achieving full implementation of SBLCBv3 by the end of March 2024.

This has been escalated to the SLT and there is an action plan in place to improve compliance prior to the end of March 2024.

5.3 Review of Small for Gestational Age births at SaTH in Quarter 3 2023 (Additional report 1)

5.3.1 All Babies born <10th centile although increased this quarter, remains below the Perinatal Institutes national GAP user average.



5.3.2 Babies <3rd centile delivered ≥ 38+0 weeks ↓ **33.3%** is **below** the PI national GAP average of 48.8%. This result suggests an improvement of babies detected and delivered by 37+6 weeks.

5.3.3 A review of babies that were born <3rd centile >37+6 weeks' gestation in Quarter 3 did not identify any themes relating to FGR not being detected (CNST monitoring standard). This is reassuring.

5.3.4 SBLCBv3/CNST year 5 mandates:
Use the PMRT to calculate the percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue. Trusts should review their annual MBRRACE perinatal mortality

report and report to their ICS on actions taken to address any deficiencies identified.

August – December 2023 PMRT report (generated for SBLCBv3 compliance) did not identify any cases not managed appropriately. It did, however, identify 2 cases that were managed appropriately.

5.0 **Progress update on Element 3: Raising awareness of reduced fetal movements (RFM).**

SBL mandates that the following measures:

5.1 Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet) on RFM, based on current evidence, best practice, and clinical guidelines, to be provided to all pregnant women by 28+0 weeks of pregnancy and RFM discussed at every subsequent contact.

5.1.1 January 2024 compliance monitoring of leaflets and discussion by 28 weeks – 100% (provided by 24+/40 gestation).

5.1.2 January 2024 compliance monitoring of RFM discussion at every subsequent contact
–1st 10 consecutive births in January retrospectively reviewed (Antenatal contacts included routine AN check, stand-alone USS, Consultant ANC, Triage, Diabetic MW F2F).
Compliance 98% (97 opportunities/95 documented discussions).

5.2 Percentage of women who attend with RFM who have a computerised CTG.

5.2.1 January 2024 compliance monitoring – 100%. LMNS agreed local ambition ≥ 90%.

5.3 Proportion of women who attend with recurrent RFM who had an ultrasound scan to assess fetal growth by the next working day (USS not required if growth scan within the last 2 weeks).

5.3.1 January 2024 compliance monitoring – 80%. LMNS agreed local ambition ≥ 80%.

5.4 Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation (SBLv3 outcome indicator).

5.4.1 In the sample reviewed (40) there were no IOL's <39 weeks for RFM alone.

5.5 Percentage of stillbirths which had issues associated with RFM management identified using PMRT (SBLCBv3 Outcome indicators).

5.5.1 PMRT report generated for 1st August 2023 – 31st December 2023 (previous report for SBLCBv3 compliance 1st August 2023 – 31st July 2023). There were no issues identified associated with RFM management.

6.0 Progress update on Element 4: Effective fetal monitoring during labour

SBL mandates that the following measures

6.1 There is a system agreed with local commissioners (CCG) based on the advice of the Clinical Network to assess risk at the onset of labour which complies with NICE.

6.1.1 23 consecutive births high risk births (requiring continuous fetal monitoring) reviewed 2- 6th February 2024– 100% compliance

6.1.2 20 Low risk intrapartum care (intermittent auscultation fetal monitoring) review 2nd November 2023- 12th January 2024– 100% compliance.

Both results are reassuring.

6.2 A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier.

6.2.1 23 consecutive births high risk births (requiring continuous fetal monitoring and 1st stage of labour over 1hour) reviewed 2 - 6th February 2024 for hourly peer reviews (fresh eyes) – 81% (per patient)/ 84% accumulative.

6.2.2 20 Low risk intrapartum care (intermittent auscultation fetal monitoring) review 2nd November 2023- 12th January 2024 for **4** hourly peer reviews – 92%% compliance.

Both results are reassuring and meet the CNST year 5 minimum ambition (80%).

NB – the February review of the high cases was undertaken in addition to the planned quarterly review undertaken by the Fetal Monitoring Midwives. The current quarter reviewed January cases only but is not published until after April. Although compliance was improving for the hourly peer reviews it hadn't reached the minimum compliance within the January cases.

Fetal monitoring action plan has been developed by the Fetal Monitoring Lead Midwife, the Intrapartum Matron and Intrapartum Manager.

Fetal monitoring actions plans -February 2024

Action	Action update	Action owner Date to be achieved
Time on delivery suite whiteboard- in red when fresh eyes due	Emailed to all coordinators	Intrapartum Matron March 2024
Chronic hypoxia sticker increased compliance	February 2024: EFM lead to design 'fit for labour poster'	Fetal monitoring lead March 2024

Multiple disciplinary team all aware when 'active second stage commenced'	Introduction of 'purple pushing pen' Time active second stage wrote in purple with time, updates continue in purple	All midwives Delivery suite coordinators March 2024
Coordinators to attend room in active 2nd stage every 30 minutes, attendance documented, confirm completion of 'Fresh eyes'		Delivery Suite coordinator Intrapartum Matron March 2024
Buddy system for 'fresh eyes' Delivery suite coordinator to assign buddy system for labourers		Delivery Suite coordinator On going
Relaunch of Team of the shift		Senior leadership team June 2024
Fetal monitoring update on band 7 meeting, delivery and triage meeting		Fetal monitor lead On going
Poster to identify what documentation is required about CTG assessments including frequency	Poster being designed by Digital midwife and fetal monitoring lead	March 2024 Digital midwife and fetal monitoring lead

7.0 Progress update on Element 5: Reducing preterm birth.

7.1 SBLCBv3 mandates

7.1.1 Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways- compliance 100%

7.1.2 Other preterm prevention standards were also required – all compliant 98-100%

This is very reassuring evidence of an embedded progress as it follows similar results to the previous review.

Results for Q3 2023
September bookings- reviewed December 2023
Total consecutive bookings reviewed 40
High 11
Intermediate 14
Low 15

	Excluded	Numerator	Denominator	SBL upper target	Compliance percentage
Preterm booking risk assessment	1	39	39	90%	100%
Risk status correct	1	39	39	na	100%
Smoking status		40	40	95%	100%
Stop smoking contact (if required)		4	4	95%	100%
Aspirin risk		40	40	90%	100%
Correct and discussed if requires aspirin		7	7	na	100%
MSU (SBL women with a preterm risk- SaTH all women tested at booking)		39	40	90%	98%
MSU follow up (if required)		0	0	90%	na
High risk at booking n= 11				na	
Referred to Preterm Prevention clinic (if required)		7	7	na	100%
Seen in PPC per guideline	5	6	6	na	100%
Intermediate risk at booking n= 14					
Referred to Preterm Prevention clinic (if required)	7	7	7		100%
Seen in PPC per guideline		7	7		100%

7.1.3 Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements (and use of decision-assist tools such as the QUiPP and QUIDS apps). The use of TVCS may also be used with or without qfFN. Further advice may be sought from UK Preterm Clinical Network, BAPM, or NICE guidance55).

December 2023 – review of compliance

Reviewing use of preterm labour predication testing in symptomatic women

NHS
The Shrewsbury and Telford Hospital
NHS Trust

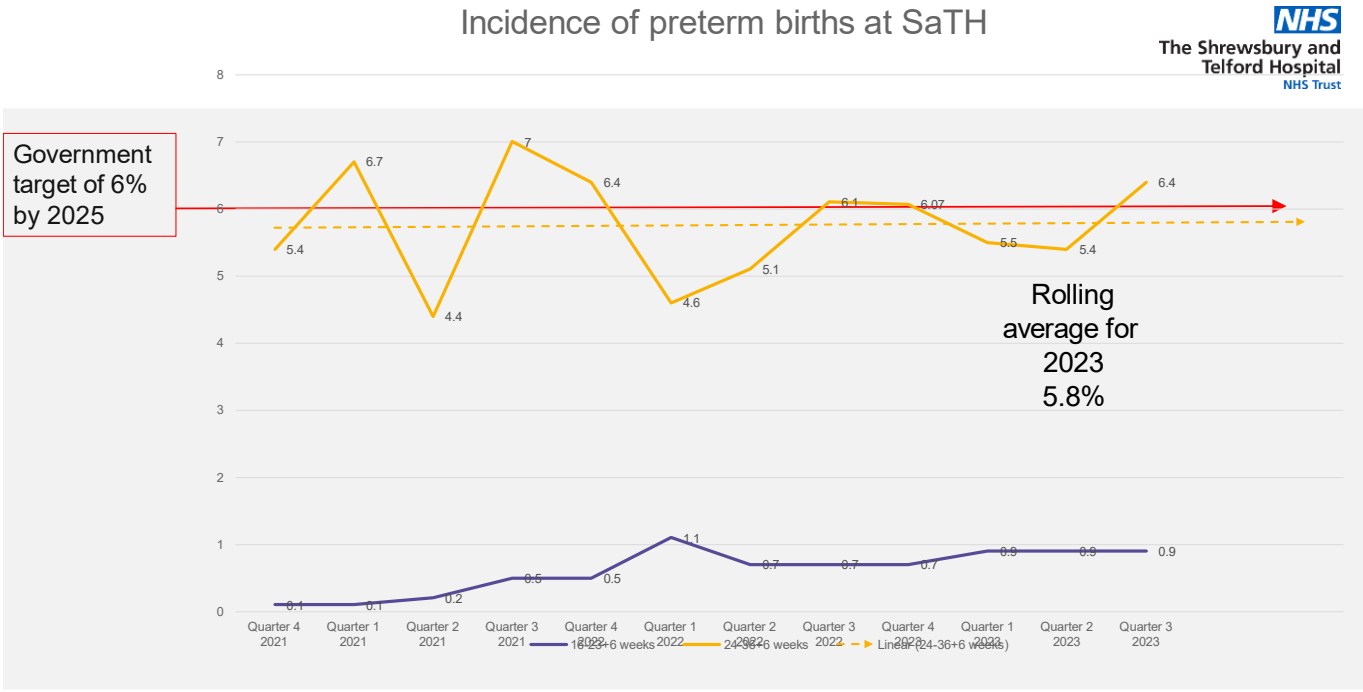
Using quantitative fetal fibronectin (qfFN) is currently the best predictor of premature labour especially if used with a decision- assist tool (SBLCBv3 standard). Due to the current global shortage of fFN cassettes other prediction tests maybe use (SBLCBv3/CNST yr5)
The System (The Trust and LMNS) has a locally set compliance target of a minimum of 80% to a stretch of 90%. This is a baseline review.
Due to the global shortage, Triage are currently under instruction to only use fFH if under 28 weeks , suspected labour and considering IUT. Partosure to be used for mildly presenting cases or cases over 28 weeks not requiring IUT

40 cases were reviewed attending Triage in December 2023 Triage BSOTS Abdominal pain used to review cases
Gestation range 22+0 -33+6 at attendance
Extracted 23- 1 case established preterm labour, 2 cases self discharged, 17 cases other pain related conditions (non labour)
Included 17 cases
Use of a prediction test 100% (4 cases fFN /13 Partosure)
No cases in all 40 were identified as a missed opportunity leading to an adverse outcome
fFN use was seen to increase slightly in the latter half of December due to a delivery of fFN cassettes

This is a very positive review.
The full use of qfFN will occur when there is confidence in regularly supplies to the Trust.

7.2 CNST mandates that a quarterly review of preterm cases must be conducted. The most recent review, for Quarter 3 of financial year 2022-23 is attached as a separate report (Additional report 2)

7.2.1. The Trust's rolling average of 5.8% for preterm births in 2023 continues to meet the national target of 6% or below of total births (24 to 36+6 weeks). The linear trend remains stable



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7.2.2 The preterm report contains **action plans** for the following preterm optimisation standards:

- Place of birth (Singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU) – to meet minimum target of 70%.
- Antenatal steroids - to meet the stretched target of 55% (minimum compliance met).
- Magnesium Sulphate - to meet the stretched target of 80% (minimum compliance met).
- Intrapartum antibiotics – **stretch target met Q3 2023**.
- Normothermia - to meet the stretched target of 80% (minimum compliance met).
- Perinatal Optimisation Pathway Compliance (new Composite metric) - **stretch target met Q3 2023 (**locally set**)**.

7.2.3 SBLCBvs3 – Process Indicator

Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements achieved (eligibility according to gestation).

This is a measure of the total optimisation standards as a package. Quarter 3 2023 demonstrated a further improvement in only the 2nd quarter this is being reviewed. The more optimisation interventions a preterm baby receives (depending on gestation), the greater the effect on reducing poor outcomes.

From the Quarter 3 2023 Preterm report

Perinatal Optimisation Pathway Compliance (Composite metric)

NHS The Shrewsbury and Telford Hospital NHS Trust

Implementation of optimisation interventions as a complete preterm perinatal optimisation pathway, including measurement and reporting of overall optimisation pathway compliance

Proportion of individual elements achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation)

Inclusive of; Place of birth, Antenatal corticosteroids, MgSO4, IV intrapartum antibiotic, Delayed cord clamping, Normothermia, MBM.

Total babies 16

Total relevant interventions 90

Total interventions achieved 67

Q3 ↑74%

Rolling percentage 70% (Q2 –Q3 2023)

(Locally agreed ambition min 50%, stretch 70%)

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7.3 SBLCBv3 mandates reviewing of perinatal mortality cases using PMRT reporting, where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue. Reporting period 1st Aug 2023 – 31st December 2023 used for SBLCBv3 Implementation tool review preparation.

- 1 case identified in the above period but had no learning recommendations. One mother did not give birth in a setting appropriate to her and/or her baby's clinical needs (Preterm twins <28/40). Relevant to outcome but managed appropriately - "*It was noted during the review of care that it would have been preferable for this patient to be transferred to a level 3 unit in view of multiple pregnancy and prematurity however patient progressed rapidly to birth her babies, without safely being able to transfer to a tertiary unit*".

  All cases of babies not born in an inappropriate birth setting (Singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g in non NICU attached units) are reviewed (live or died). Cases of babies born alive are also shared with the Midlands preterm network for regional data and learning.

8.0 Progress update on Element 6: Management of Pre-existing Diabetes in Pregnancy (new Element in version 3)

8.1 Pre-existing and gestational Diabetes guideline has been updated to include the following SBLCBv3 standards (evidenced already in current practise)

8.1.1 Women with type 2 diabetes will be offered intermittently scanned CGM and be provided with appropriate education and support to use this –

- SBLCBv3/CNST year5 mandated that woman that were not achieving glycaemic targets in pregnancy were to be offered flash monitoring. The Trust has decided to offer to all Type 2's as a gold standard. This is now in practice and currently monitored by the Diabetic Midwifery Team.

8.1.2 SBLCBv3 mandates

Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements. The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife.

- The current clinic appointment plan has separated to allow women with pre -existing Diabetes to have grouped appointments.
- To date the Diabetes Dietician is not part of the clinic team – this is a **concern**, but progress is being made in recruitment

8.1.3 SBLCBv3 mandates

Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.

- This policy is not yet in place and is of **concern** – there is however progress on an SOP/pathway.

APPENDIX 7

The Shrewsbury and Telford Hospital NHS Trust

Saving Babies Lives Element 2

Review of Small for Gestational Age births at SaTH in Quarter 3 2023-2024

and

Accumulative graphical data commencing 2020

Lindsey Reid
Lead Midwife for Saving Babies' Lives

Data collated January 2024

Introduction

Fetal Growth Restriction (FGR) is the most important condition associated with stillbirths;
excluding congenital abnormality, FGR accounts for about 50% stillbirths and neonatal deaths (ref 1 and 2).

A fetus affected by FGR has a 5-11-fold increased risk of in-utero death (ref 3)

FGR is a precursor of cerebral palsy (ref 4)

Introduction

The Shrewsbury and Telford Hospital NHS Trust

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice for providers and commissioners of maternity care across England to reduce perinatal mortality.

The newest update to the care bundle, version 3 (ref 5) was released in June 2023. It comprises of 6 individual elements

Element 2

Element 2 covers Fetal Growth: Risk assessment, surveillance, and management. Building on the widespread adoption of mid-trimester uterine artery Doppler screening for early onset fetal growth restriction (FGR) and placental dysfunction, Element 2 seeks to further improve FGR risk assessment by mandating the use of digital blood pressure measurement. It recommends a more nuanced approach to late FGR management to improve the assessment and care of mothers at risk of FGR, and lower rates of iatrogenic late preterm birth.

Definitions and Abbreviations

The Shrewsbury and Telford Hospital NHS Trust

Fetal Growth Restriction (FGR) – birth centile under (<) the 3rd

Small for Gestational Age (SGA) – birth centile under (<) the10th to above (>) the 3rd

Estimated fetal weight (EFW) - fetal weight estimated from ultrasonic fetal biometry (measurements)

Induction of labour – IOL

Perinatal mortality review tool (PMRT)- national standardised perinatal mortality review

Serial Growth Scan (SGS)

Ultrasound Scan (USS)

≥ - equal to and above

≤ - equal to and below

Aims

To monitor compliance with the standards contained within SBLCBv3

Standards

The Shrewsbury and Telford Hospital NHS Trust

- Monitoring for all babies born below the 10th centile regardless of gestation.
- Monitoring of babies born after 39+6 and between the 10th and 3rd centile to provide an indication of detection rates and management of SGA babies (SBLCBv3 Element 2).
- Monitoring of babies under the 3rd centile born after 37+6 weeks. This is a measure of the effective detection and management of FGR. (SBLCBv3 Element 2, Outcome indicator)
- Monitoring babies born >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected. (SBLCBv3 Element 2, Outcome indicator)

Methodology

A retrospective quarterly data review of babies born below the 10th centile.

Time period– 1/10/23 – 31/12/23 (Quarter 3 2023 -2024)

Cases analysed – 1036 babies (live born and stillborn from 24 weeks gestation whose majority of antenatal care was provided by SaTH)

Data - Extracted from Badgernet (Maternity Information Systems)

Method of analysis – Microsoft Excel

Results

The next slide shows SaTH's internally reviewed data.

The Perinatal Institute's (PI) national GAP (Growth Assessment Protocol (ref 6) user average data is included as comparative data.

All SGA's and <3rd centile births

The Shrewsbury and Telford Hospital NHS Trust

Quarter 3 2023-2024		SaTH reviewed data	Perinatal Institute National GAP user average Data Comparison
Total inclusive births	N	1036	na
SGA rate <10th – 0 centile	N %	142 13.7	 14.0
SGA all <10th centile detection rate	N %	64 45.1	 42.9
<3rd at birth	N %	33 3.2	 4.3
<3rd detection rate (all gestations)	N %	23 69.7	 60.8
Detection rate of <3rd centiles born before 38+0 weeks	N %	18 78.2	 No data
Babies born <3rd centile from 38+0 weeks	N %	11 33.3	 47.3
Detection rate of <3rd centiles born after 38+0 weeks	N	5 45.5	 No data

10th - 3rd centile births (SGA)

The Shrewsbury and Telford Hospital NHS Trust

Quarter 3 2023-2024		SaTH reviewed data	Perinatal Institute National GAP user average Data Comparison
SGA rate <10th – 3rd centile	N %	107 10.3	 9.7
SGA detection rate <10th – 3rd centile	N %	41 38.3	 33.4
Babies <10th >3rd centile delivered on or after 40+0 weeks	N %	36 33.6	 24.3
SGA detected after 40+0 weeks	N %	7 6.5	 3.3

≥3rd centile births where FGR suspected

The Shrewsbury and Telford Hospital NHS Trust

Quarter 3 2023-2024		SaTH PI data	Perinatal Institute National GAP user average Data Comparison
Babies born before 39+0 weeks	N	38	
where FGR suspected	%	3.9	4.8
- birth weight centile ≥ 3rd			

NB. PI data only for the Trust – data from GROW1.5 report (not verified internally).
Current CNST data review requirement.

Conclusion

The Shrewsbury and Telford Hospital NHS Trust

All Babies born <10th centile **13.7%**, although increased, it remains just **below** the PI national GAP average of 14.0%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies <10th centile was **45.1%** this was **better** than the PI national GAP average of 42.9%.

Babies born <3rd centile **3.2%** which was **better** the PI national GAP average of 4.3%. This continues to be a positive result

Antenatal detection (suspected by ultrasound assessment) rate of all babies <3rd centile was **69.7%** this was **better** than the PI national GAP average of 60.8%. This continues to be a positive result

Babies <3rd centile delivered ≥ 38+0 weeks **33.3%** is **below** the PI national GAP average of 47.3%. This result suggests a continued improvement of babies detected and delivered by 37+6 weeks

Conclusion

The Shrewsbury and Telford Hospital NHS Trust

Babies born between the10th and 3rd centile ↑ **10.3%** which was just **above** the PI national GAP average of 9.7%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies born between the 10th and 3rd centile was ↑ **38.3%** this was **above** the PI national GAP average of 33.4%.

Babies <10th and >3rd centile, delivered ≥ 40+0 weeks was ↓ **33.9%** which is **above** the PI national GAP average of 24.3%. The linear trend for SaTH remains stable (see graphs section)

Babies <10th and >3rd centile, detected ≥ 40+0 weeks was ↑ **6.5%** which is **above** the PI national GAP average of 3.3%.

Conclusion

The Shrewsbury and Telford Hospital NHS Trust

Babies born before 39+0 weeks where FGR **was** suspected with a birth weight centile ≥ 3rd ↑**3.9%** this was below the PI average of 4.8% and continues to be a positive result.

Caution on data

This is a new SBLCBv3 outcome indicator review to access if there is an over estimation of FGR's and/or IOL's. Trusts have found this difficult and time onerous to achieve. The PI have formulated the Trusts data, but it has not been internal verified due to an insufficient method to review on Badgernet. It can however give the Trust an overview as to whether further internal reviews are required.

The PI data will not include babies that have other factors that required IOL i.e. SGA with reduced fetal movements or that have been born spontaneously.

The national SBLCBv3 team are reviewing whether this information will provide any long-term productive data.

< 3rd centile birth review of births >37+6 weeks

The Shrewsbury and Telford Hospital NHS Trust

< 3rd centiles born > 37+6 weeks cases are reviewed to try to identify any themes that require further investigation and improvement plans

The cases reviewed for care provided from booking to birth

The following slides give an overview of detection and a brief description of cases <3rd centile births > 37+6 weeks

< 3rd centile case overview (n=36)

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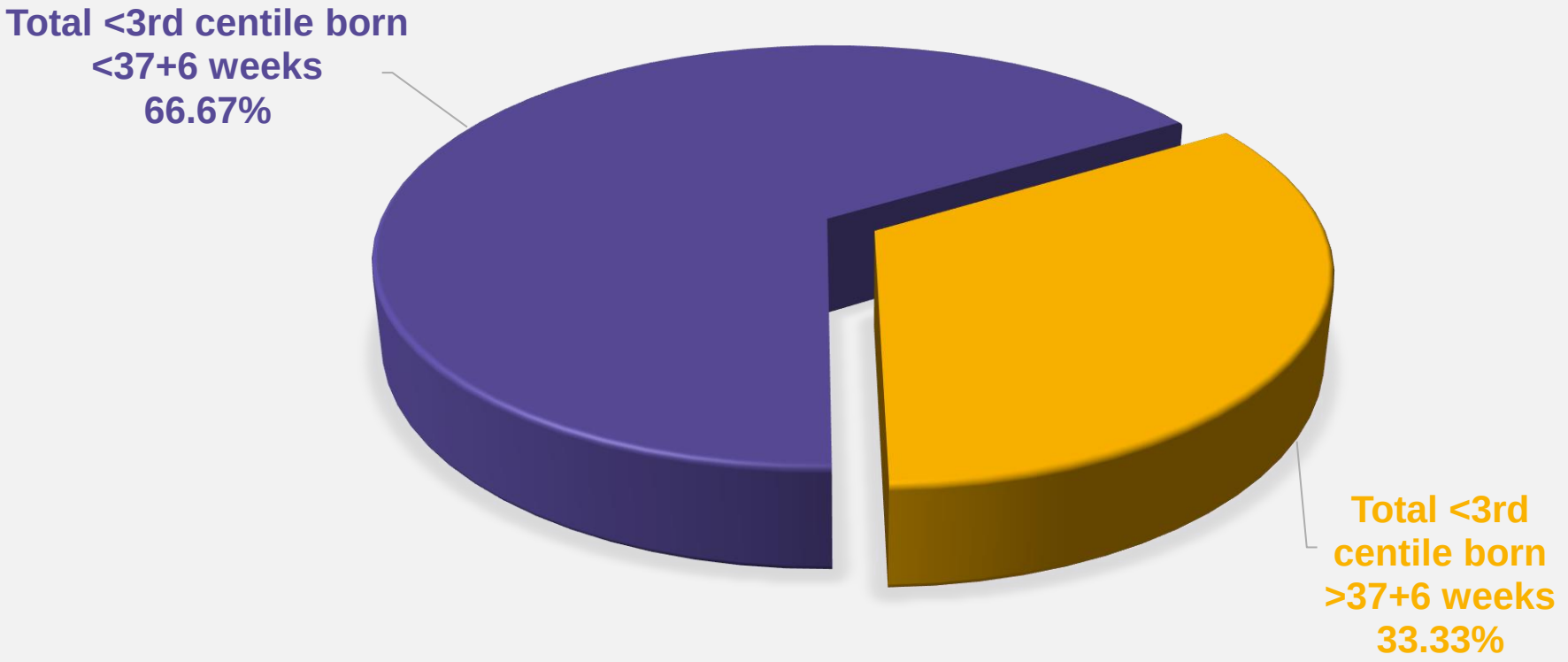

Around 2/3rds of the <3rd centile babies were born **before** 37+6 weeks . It is a further improvement overall. This is a measure of the effective detection and management of FGR (SBLCBv3).

<3rd centile cases born >37+6 weeks n=12

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Quarter 3 had 12 babies born >37+6 weeks < 3rd centile

5 were detected <37+6 by USS either final serial growth scan or referral from SFH assessment

- 1 case was suspected as SGA prior to 37+6, IOL at 38+ as also RFM.
- 1 case was suspected as SGA prior to 37+6, SROM at 38+5, Caesarean brought forward.
- 1 case suspected FGR at 38+1 serial scan. IOL commenced same day.
- 1 case suspected FGR at 39+2 serial scan. IOL commenced next day.
- 1 case was suspected SGA at 37+1, unable to travel to Triage that day. Follow up scan arranged alongside a Consultant clinic but spontaneously delivered prior.

<3rd centile cases born >37+6 weeks continued n=12

The Shrewsbury and Telford Hospital NHS Trust

7 cases not detected.

These cases included women having serial growth scans and scans following a referral from a Community Midwife.

- All cases correctly risk assessed at booking and were commenced on the correct fetal surveillance pathway.

Evaluation

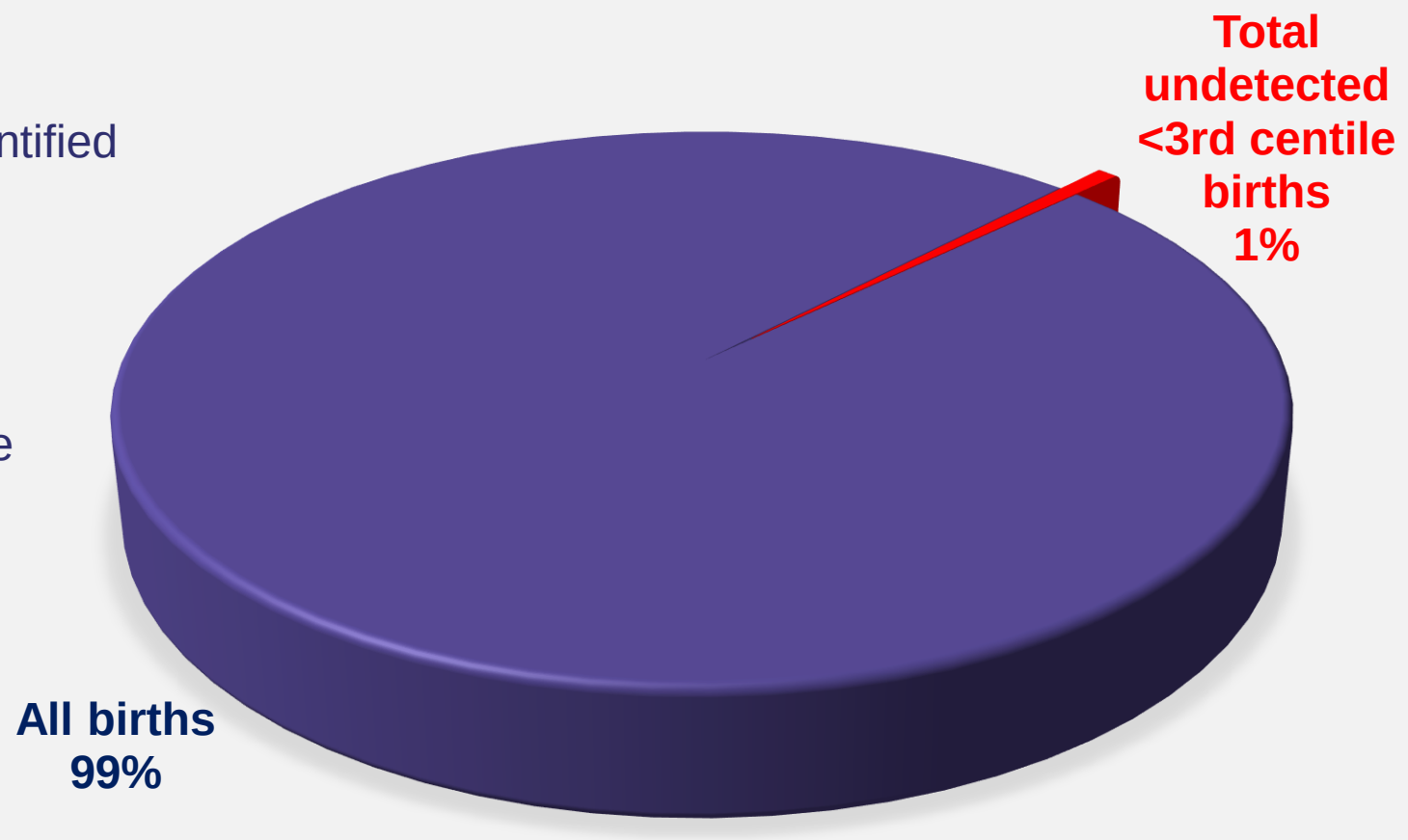
The Shrewsbury and Telford Hospital NHS Trust

Quarter 3 births (1039),

7 babies born < 3rd centile were not identified before birth (any gestation)

= ↔1.0% of all births

- No cases from SFH only surveillance
- No missed opportunities identified
- No themes identified over 2023



Ultrasound detection

Ultrasound surveillance using EFW is a screening tool and **not** diagnostic due to the inherent issues in calculation of EFW formulas

The most accurate model is Hadlock 3 which is used in SaTH

Reported standard deviation for Hadlock formula is 7.3%, which means;

- **95% of babies have a measured birth weight within 15% of EFW**
- However, 1 in 20 babies have a measured birthweight more than 15% of EFW

Additional consideration

- SaTH currently do not save 3rd trimester growth ultrasound images electronically, therefore, complete case evaluation not possible. This has also been highlighted from PMRT case reviews

Recommendation

- Consider implementation of electronic storage of 3rd trimester growth scan images

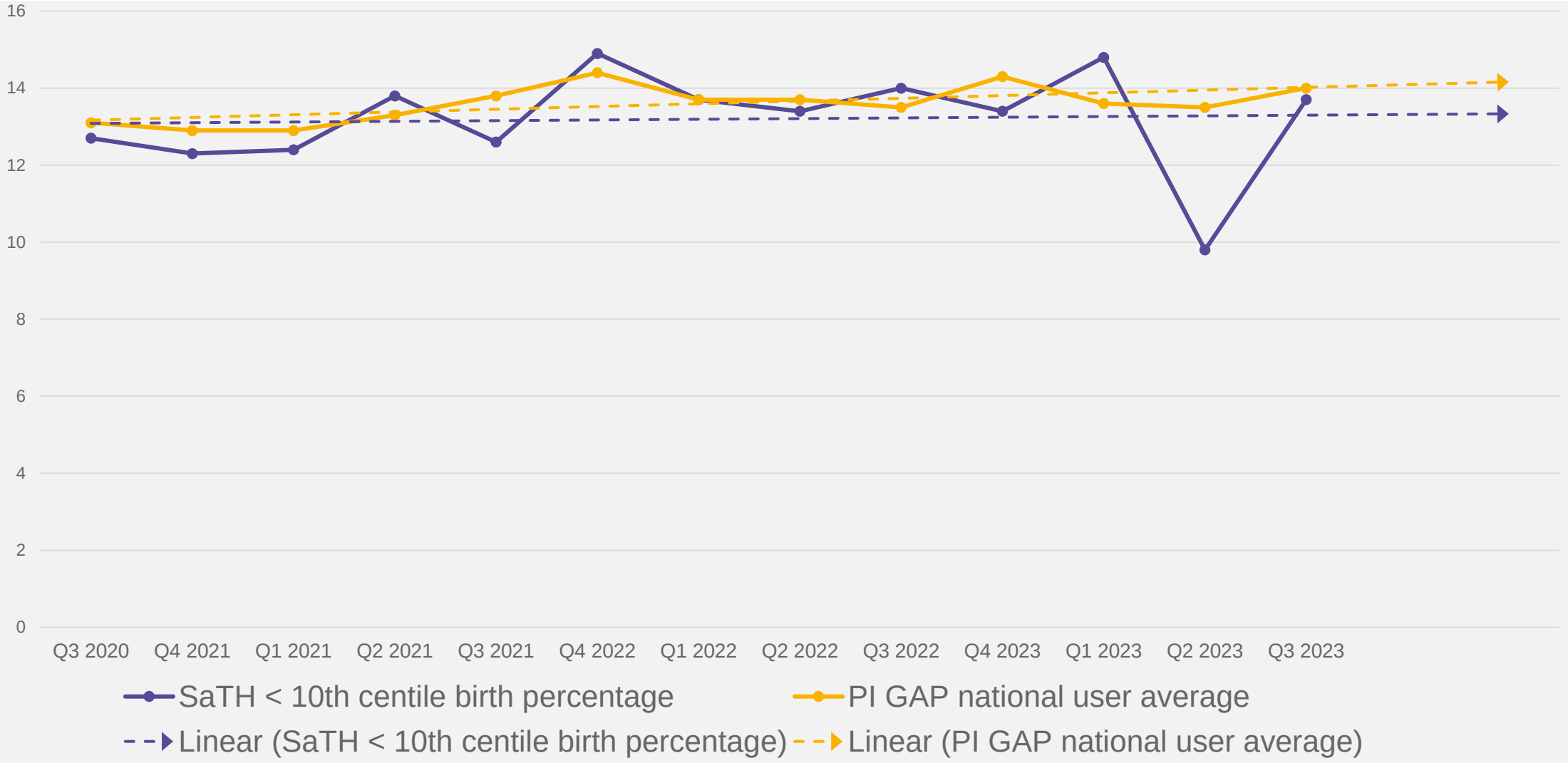
Accumulative data

The following slides show accumulative data of:

- All babies born <10th centile at SaTH compared to Perinatal Institute's national GAP average
- Babies born <10th >3rd centile
- Babies born < 3rd centile

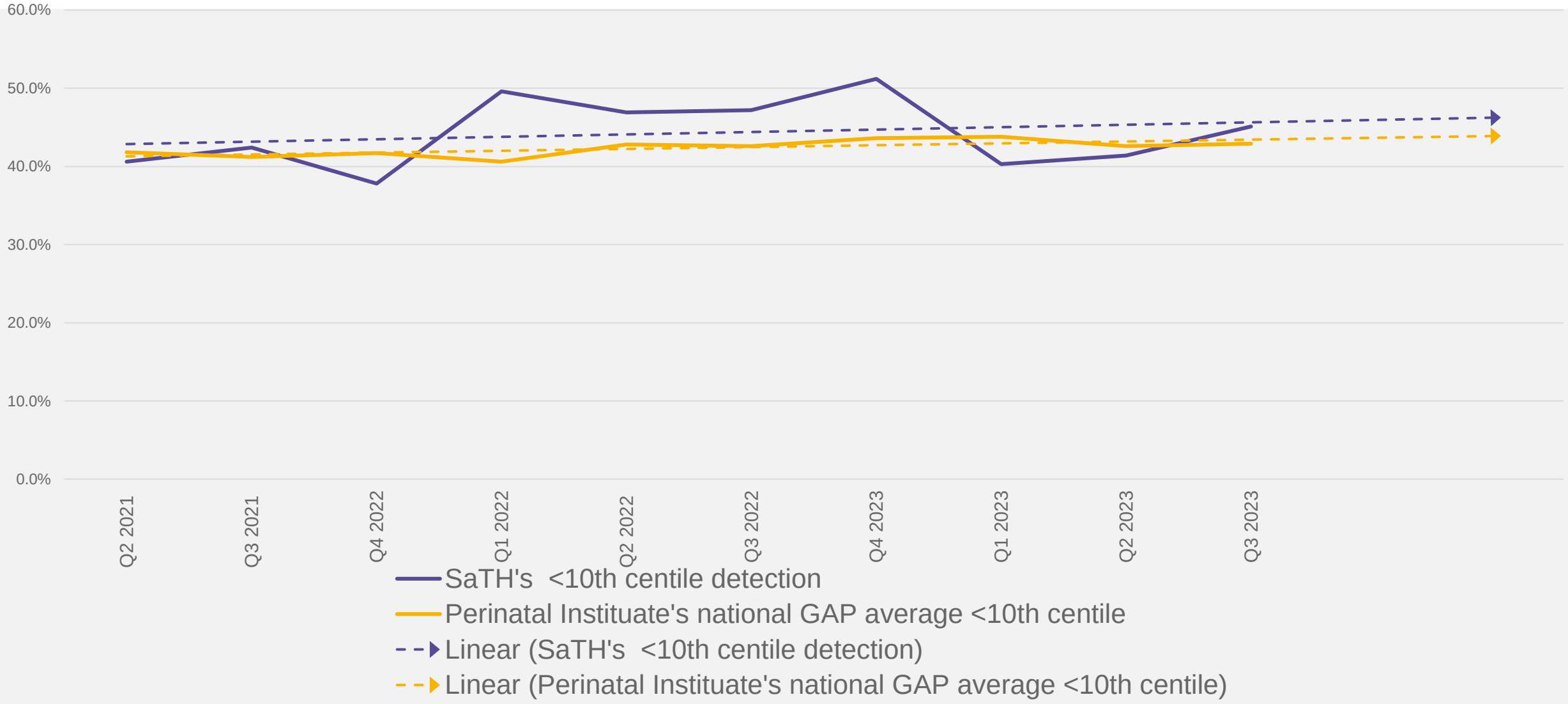
Babies born <10th centile at SaTH compared to the Perinatal Institute's national GAP User average

The Shrewsbury and Telford Hospital NHS Trust



SaTH's <10th detection rate compared to the Perinatal Institutes national GAP user average

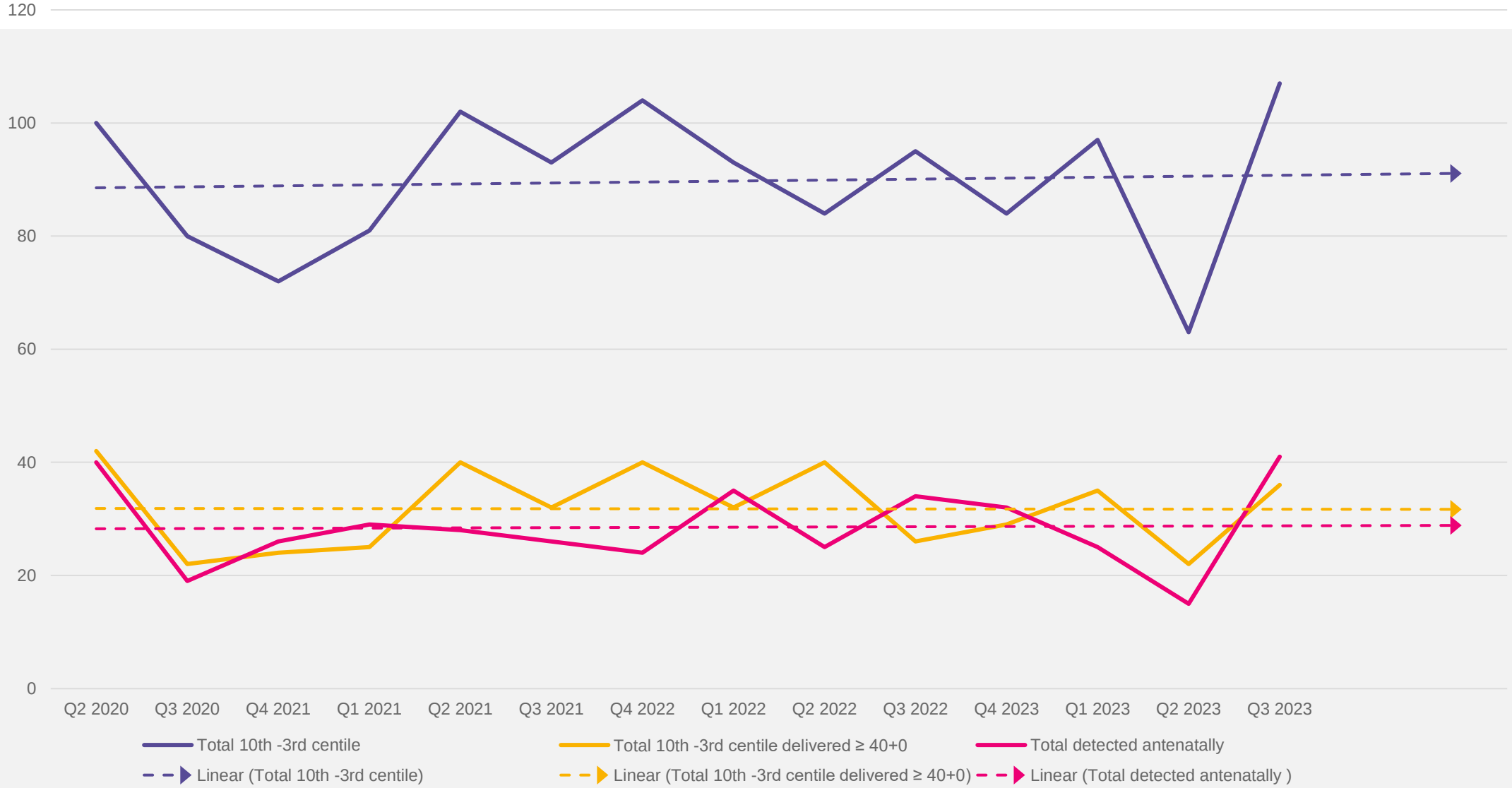
The Shrewsbury and Telford Hospital NHS Trust



< 3rd centile birth data

The Shrewsbury and Telford Hospital NHS Trust

Expanded 10th to 3rd centile birth data



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2. Beamish N, Francis A, Gardosi J. Intrauterine growth restriction as a risk factor for infant mortality. *Arch Dis Child Fetal Neonatal Ed* 2008;**93**(Suppl I):Fa83.
3. Clausson B, Gardosi J, Francis A, Cnattingius S. Perinatal outcome in SGA births defined by customised versus population based birthweight standards. *Br J Obstet Gynacol* 2001;**108**:830-4.
4. Jacobsson B, Ahkin K, Francis A, Hagberg G, Hagberg H, Gardosi J. Cerebral palsy and restricted growth status at birth: population based case-control study. *Br J Obstet Gynacol* 2008;**115**:1250-1255
5. NHS England (2023) Saving Babies' Lives A care bundle for reducing perinatal mortality version 3 NHS England » Saving babies' lives: version 3
6. GAPguidance.pdf (perinatal.org.uk)

APPENDIX 8

The Shrewsbury and Telford Hospital NHS Trust

Quarter 3 2023/2024 Review of Preterm Births

Lindsey Reid
Lead Midwife for Saving Babies' Lives
Data collated January 2023

Background

Version 3 of the Saving Babies' Lives Care Bundle (SBLCBv3)((ref 1)), was produced to build on the achievements of version 1 and 2. The 3rd version of the care bundle draws on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. There are 6 elements within the care bundle.

Element five - Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented was introduced in version 2.

This element of the care bundle was developed in response to The Department of Health's 'Safer Maternity Care' report which extended the 'Maternity Safety Ambition' to include reducing preterm births from 8% to 6%.

This element focuses on three intervention areas to improve outcomes, which are **prediction** and **prevention** of preterm birth and better **preparation** when preterm birth is unavoidable.

Report aim

Neonatal care options discussion prior to birth.

Perinatal Optimisation pathway standards (antenatal, peripartum and neonatal)

SBLCBv3 Perinatal outcome indicators including

- Singleton preterm birth data
- Mortality to discharge in very preterm babies (NNAP definition)
- Serious Neonatal brain injuries (NNAP definition)

Neonatal care options discussion

Ensuring the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.

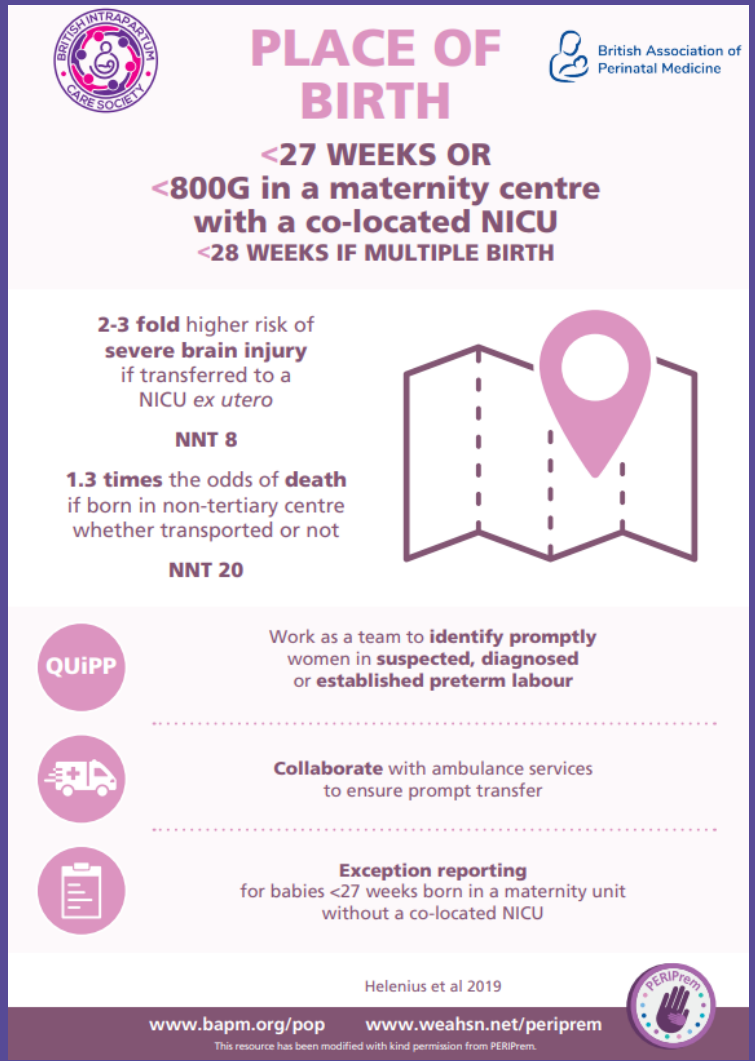
In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation

Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

1. Place of birth

Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)



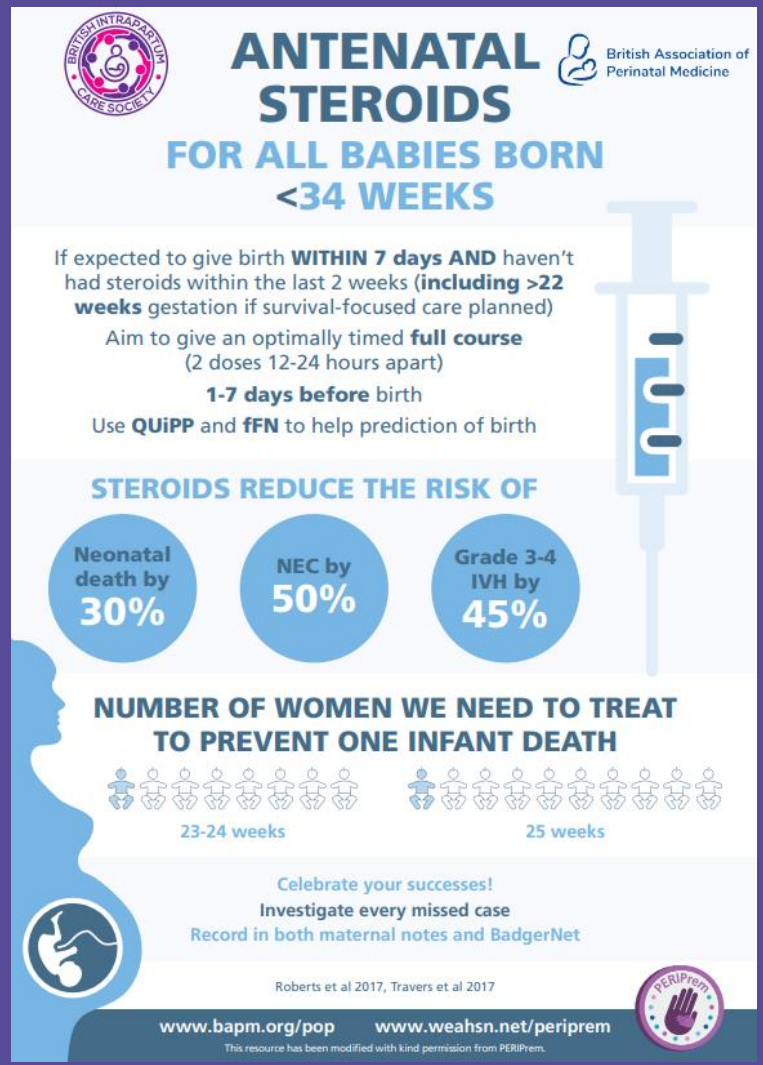
Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

2. Antenatal corticosteroids

a. Percentage of live births (less than 34+0 weeks) receiving a full course (2 injections, 12 to 24 hours apart) of antenatal corticosteroids, **within** seven days of birth

b. Percentage of live births (less than 34+0 weeks) occurring **more** than seven days after completion of their first course of antenatal corticosteroids

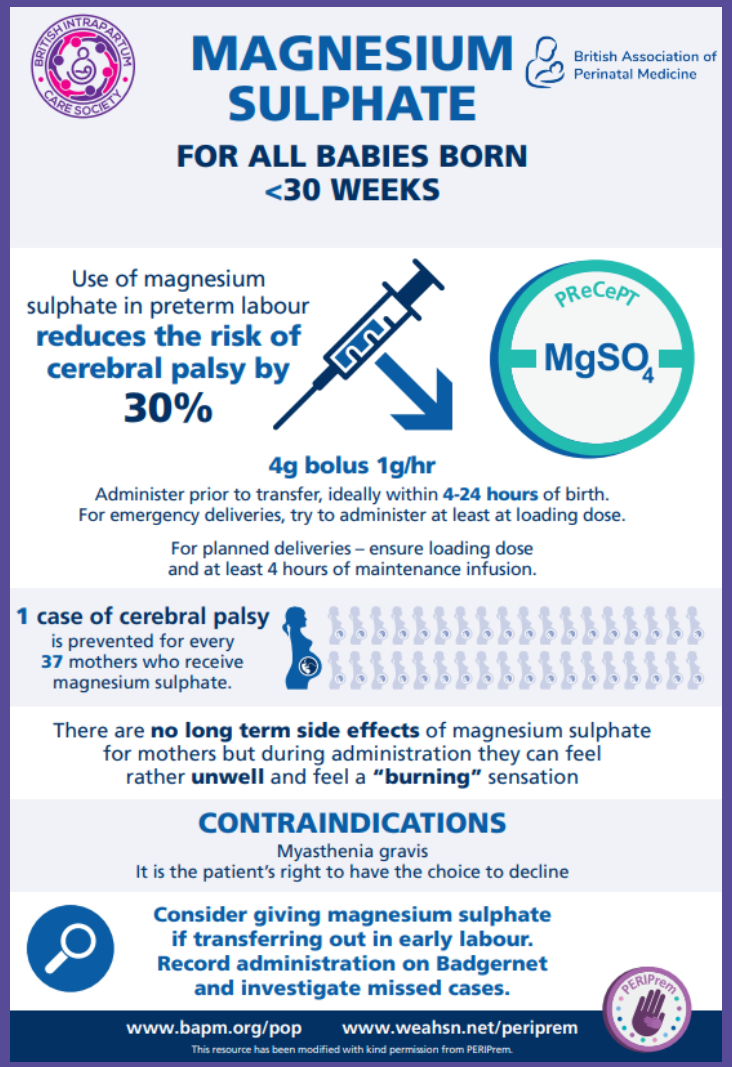


Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

3. Magnesium sulphate

Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth

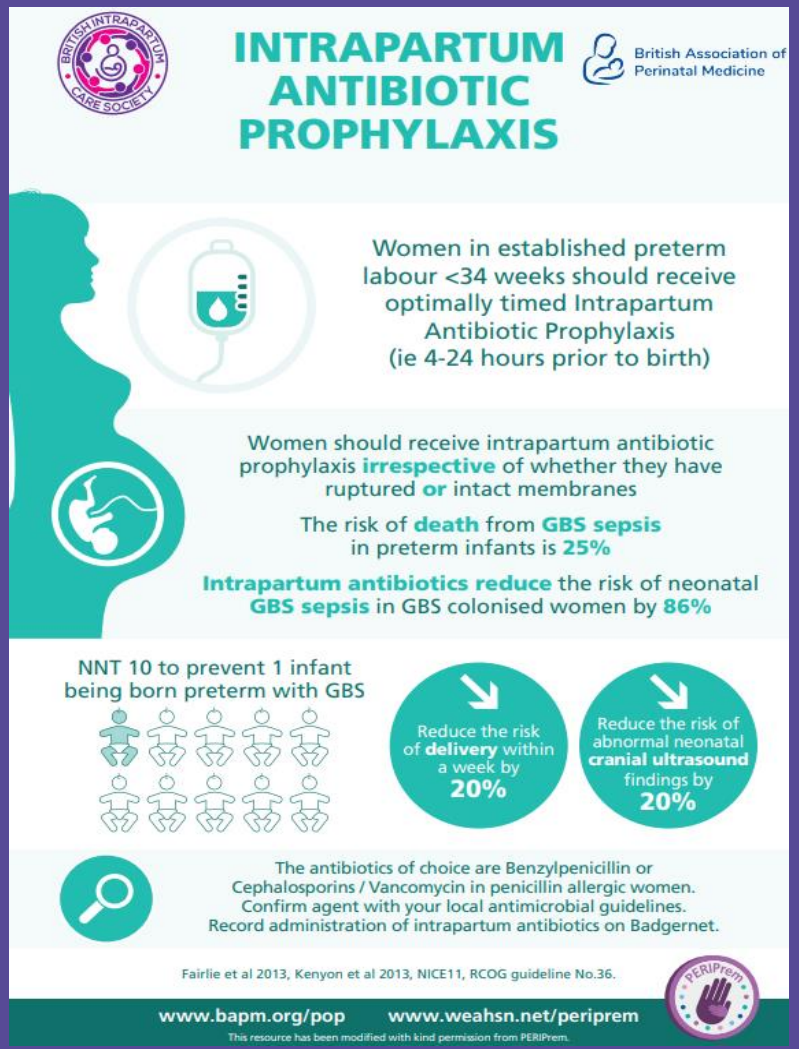


Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

4. Intrapartum antibiotics

Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection.



Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

5. Cord Management

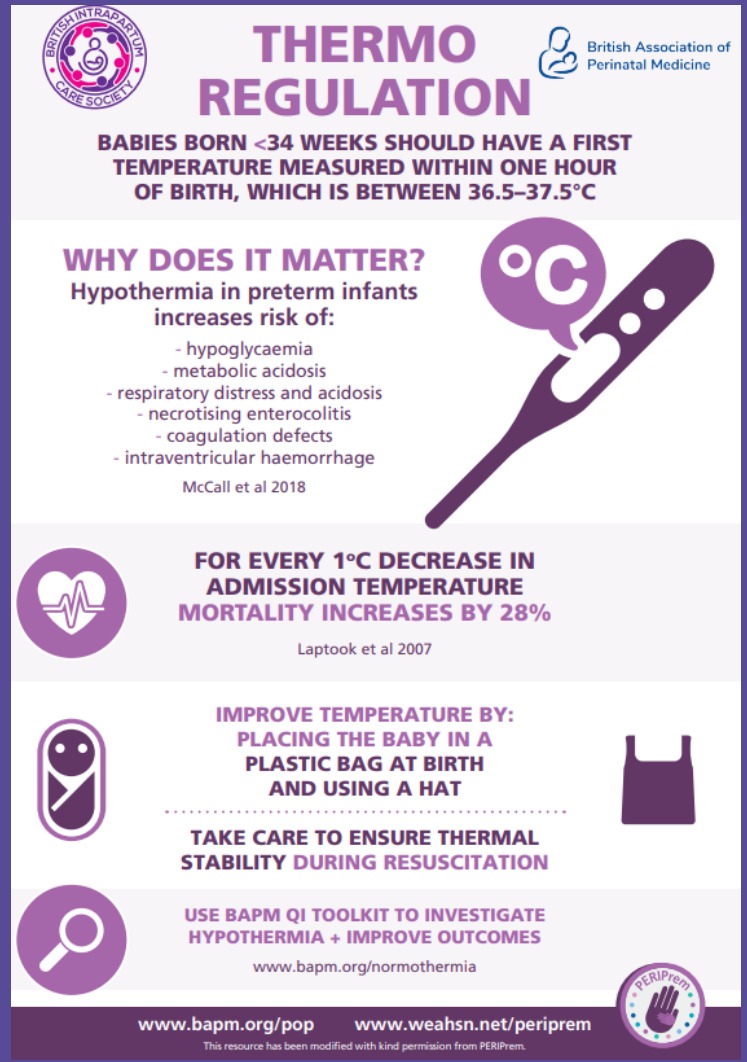
Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.

Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

6. Normothermia

Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.

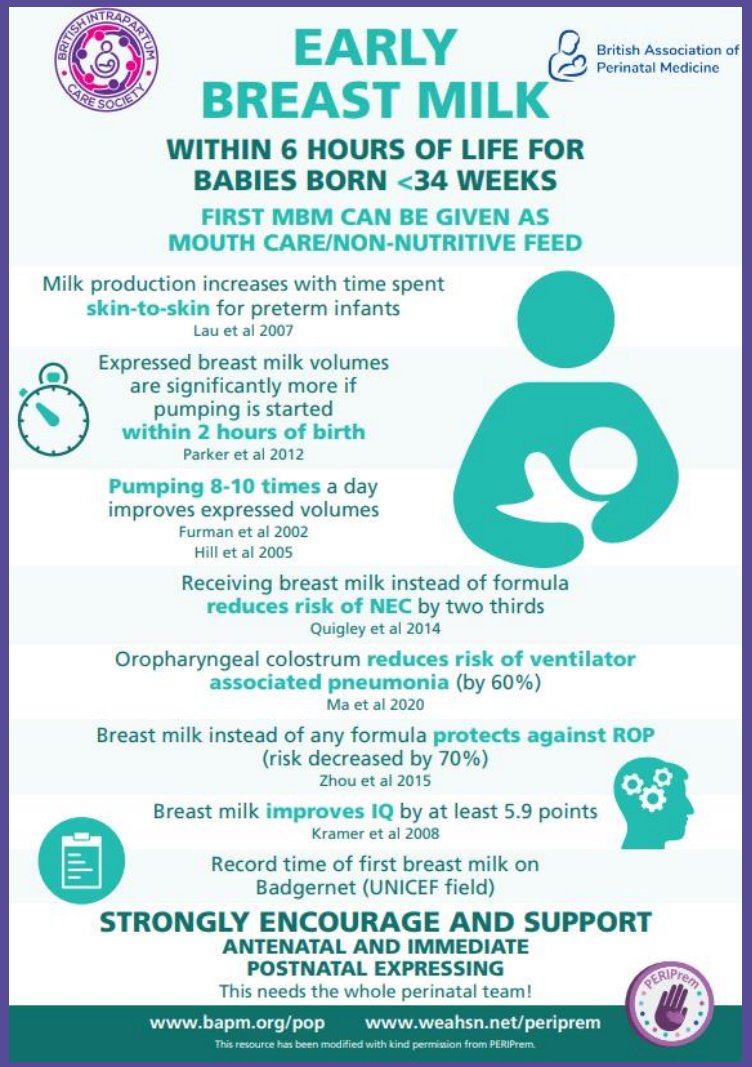


Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

7. Early maternal breast milk (MBM)

Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.



Methodology of this report

The Shrewsbury and Telford Hospital NHS Trust

A retrospective review of births between 16+0 and 36+6 weeks using Badgernet (maternity information system)

Time period – 1/10/23 – 31/12/23

Cases analysed –1039 births (single and multiple ≥16 weeks)

Method of analysis – Microsoft Excel

Results

Now included in the SBLCB version 3 perinatal optimisation standards – babies born from 22 weeks of gestation where active management is agreed

There was 1 case between 22 and 23+6 weeks in this quarter where active management was agreed.

Neonatal care options discussion

The Shrewsbury and Telford Hospital NHS Trust

Number of women that delivered preterm that have had a discussion with the neonatal team regarding care options.

Cases in review period 1 - 22+0-23+6 weeks

10 - 24+0-33+6 weeks

↑**90%** documented pre-birth discussion.

1 case Neonatal team documented as present, but pre-birth discussion not facilitated,

Excluded

6 case's emergency caesarean's – no opportunity

1 rapid birth – no opportunity

(No current national ambition –locally agreed ambition – min 65%- stretch improvement 80%)

Neonatal care options discussion – action plan

The Shrewsbury and Telford Hospital NHS Trust

Action	Target	Update	RAG rating according to local ambition
Number of women that delivered preterm that have had a discussion with the neonatal team regarding care options.	Ambition Stretch of ≥80%	6/10/23 findings reported to Senior Leaders for cascade to relevant Obstetric/Midwifery and Neonatal staff 4/1/24 ambition achieved in Q2, continue to monitor through preterm birth reviews	
Share reviews with SaTH's Preterm Lead team	na	13/10/23 next meeting 12/1/24	na
Maternity staff update on Day 2- mandatory training	na	Occurs monthly – delivered by SBL Lead Midwife	na

1. Place of birth (from financial year 2022-2023)

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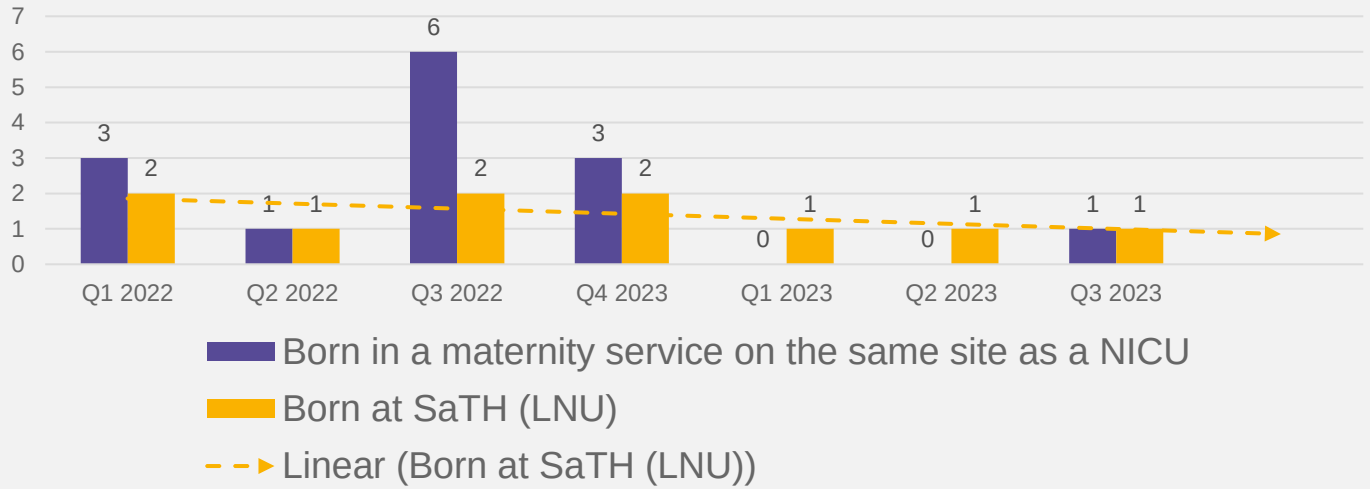
Singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight (EFW) of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)



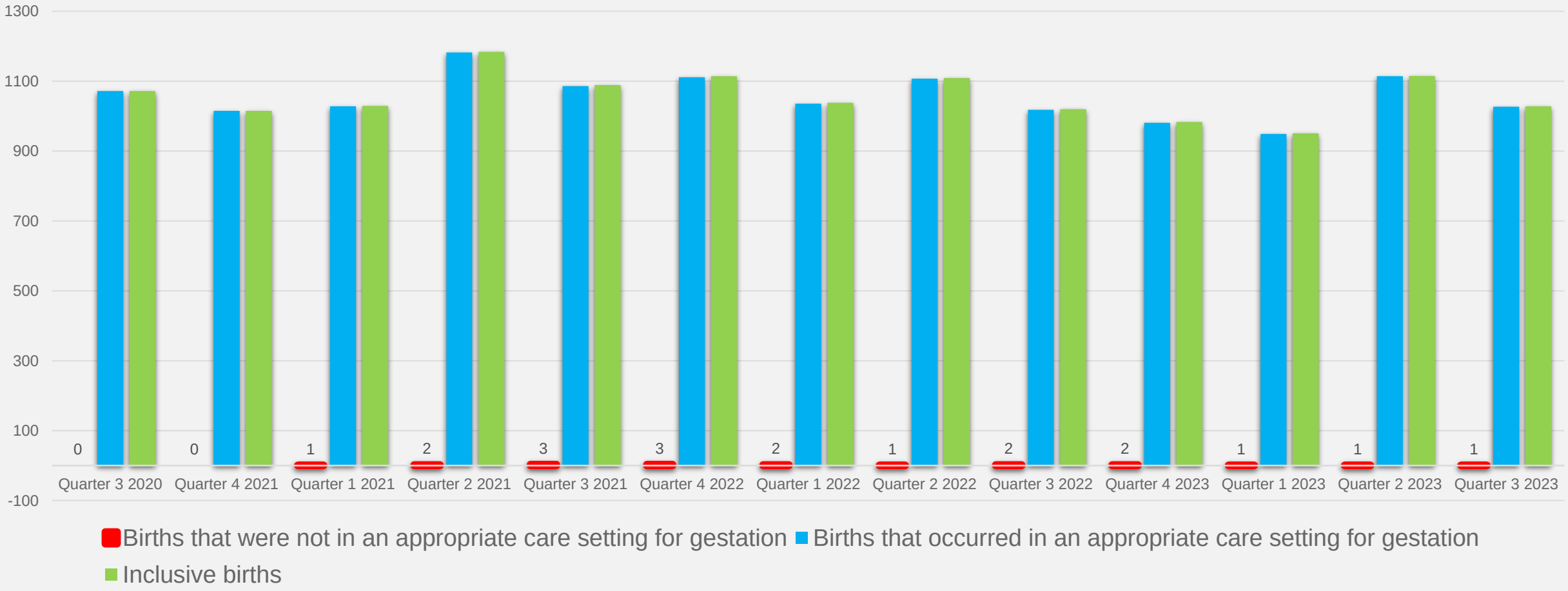
For Quarter 3, 1 case was born in another Trust following IUT for severe placental disfunction and EFW approximately 600gms .
1 case occurred at SaTH at 23+5 weeks. Attempts to stabilise for IUT but delivered spontaneously.

The linear trend babies born at SaTH has fallen by **half** since Q1 2020 which follows the falling extreme preterm birth rates at SaTH.

All cases are reviewed both internally and externally (Midlands Preterm Network group). No cases have been missed opportunities for IUT for at least the last year. The rolling average is 58% of babies were born in a maternity service on the same site as a NICU following IUT from SaTH.

1. Place of birth - overview

The Shrewsbury and Telford Hospital NHS Trust



Overall, 99.9% of babies born occurred in the right birthing location in quarter 3. This is a continuing theme.

Place of birth– action plan

The Shrewsbury and Telford Hospital NHS Trust

Action	Target	Update	RAG rating according to local ambition
Review cases that were born at SaTH to detect any missed opportunities and cascade learning	Ambition Min 70% Stretch of ≥80%	13/10/23 no missed opportunities identified Q2 04/1/24 no missed opportunities identified Q3	
Share reviews with SaTH's Preterm Lead team	na	13/10/23 next meeting 12/1/24	na
Share information within the Midlands Preterm network	na	continuous	na
Maternity staff update on Day 2- mandatory training	na	Occurs monthly – delivered by SBL Lead Midwife	na

2a. Antenatal corticosteroids (Nb. now includes multiples births (ref1))

The Shrewsbury and Telford Hospital NHS Trust

Percentage of live births (less than 34+0 weeks and including births 22 – 23+6 weeks where active management was requested) receiving a full course (2 injections, 12 to 24 hours apart) of antenatal corticosteroids, within seven days of birth

Quarter 3 ↓29%

Continuous rolling average currently **48.5%**

(CNST ambition – minimum 40%, stretch 55% (reduced from 80% in version 2))

5 cases, (including a 23+5 extreme premature baby) received a single dose of antenatal steroid. Birth occurred prior to 2nd dose either spontaneously or due to an emergency

No missed opportunities identified

1 case declined antenatal steroids

1 case appropriately received antenatal steroids over 7 days before delivery (next slide)

2b. Antenatal corticosteroids (Nb. now includes multiples births (ref1))

The Shrewsbury and Telford Hospital NHS Trust

Percentage of live births (less than 34+0 weeks) occurring **more** than seven days after completion of their first course of antenatal corticosteroids

↓**6%** (percentage should be low)

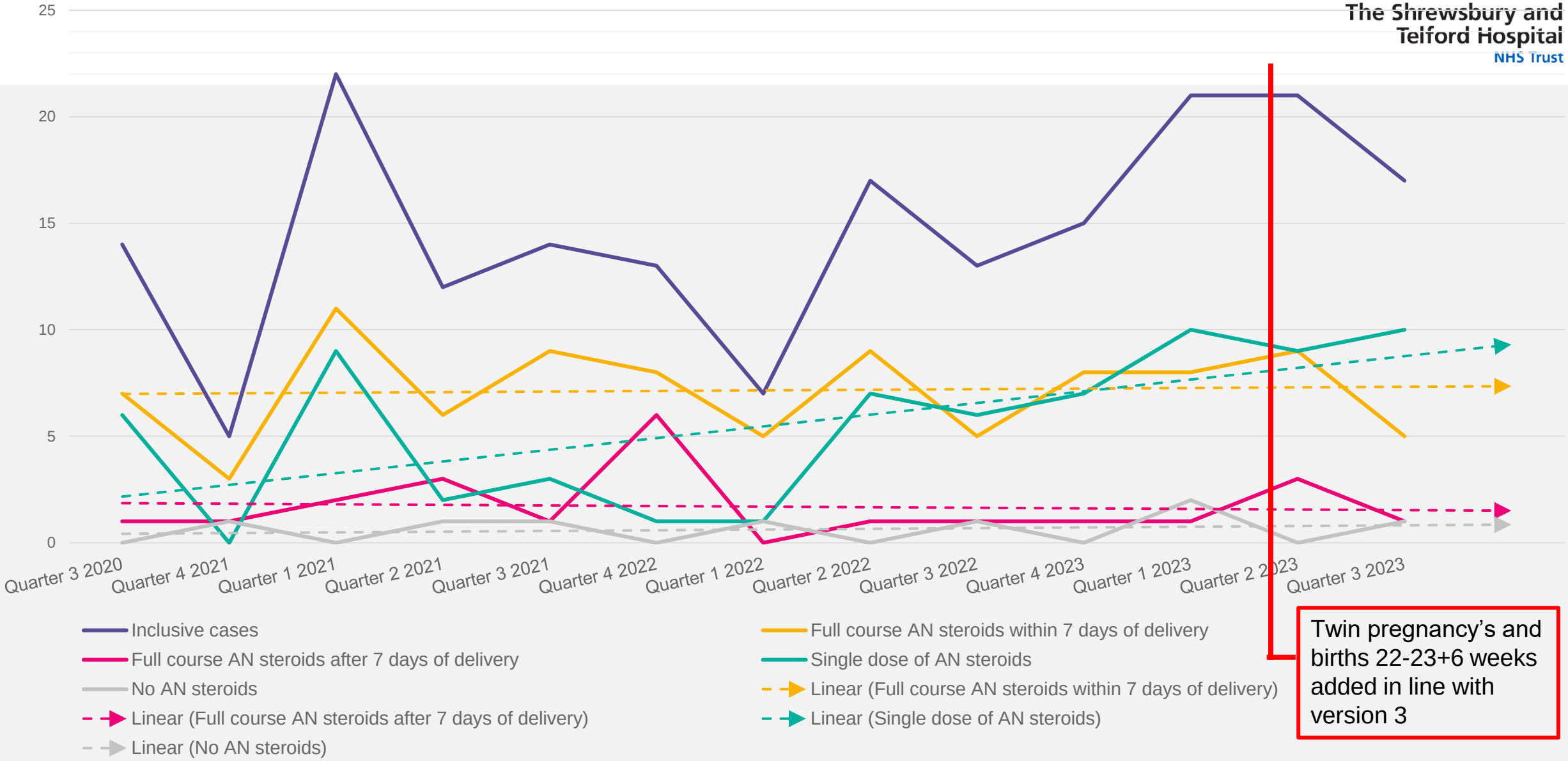
1 case was administered a full course due to premature rupture of membranes (PPROM) as per guidance.

Antenatal corticosteroids– action plan

The Shrewsbury and Telford Hospital NHS Trust

Action	Target	Update	RAG rating according to local ambition
Review cases that were born at SaTH to detect any missed opportunities and cascade learning	Ambition Min 40% - met Stretch of 55%	13/10/23 no missed opportunities identified in Q2 4/1/24 no missed opportunities identified in Q3	
Share reviews with SaTH's Preterm Lead team	na	13/10/23 next meeting 12/1/24	na
Share information within the Midlands Preterm network	na	continuous	na
Maternity staff update on Day 2- mandatory training	na	Occurs monthly – delivered by SBL Lead Midwife	na

Antenatal Steroids



Twin pregnancy's and births 22-23+6 weeks added in line with version 3

3. Magnesium sulphate (MgSO4)

The Shrewsbury and Telford Hospital NHS Trust

Percentage of singleton live births (less than 30+0 weeks and including births 22 – 23+6 weeks where active management was requested) receiving magnesium sulphate within 24 hours prior to birth

Cases in review period 5

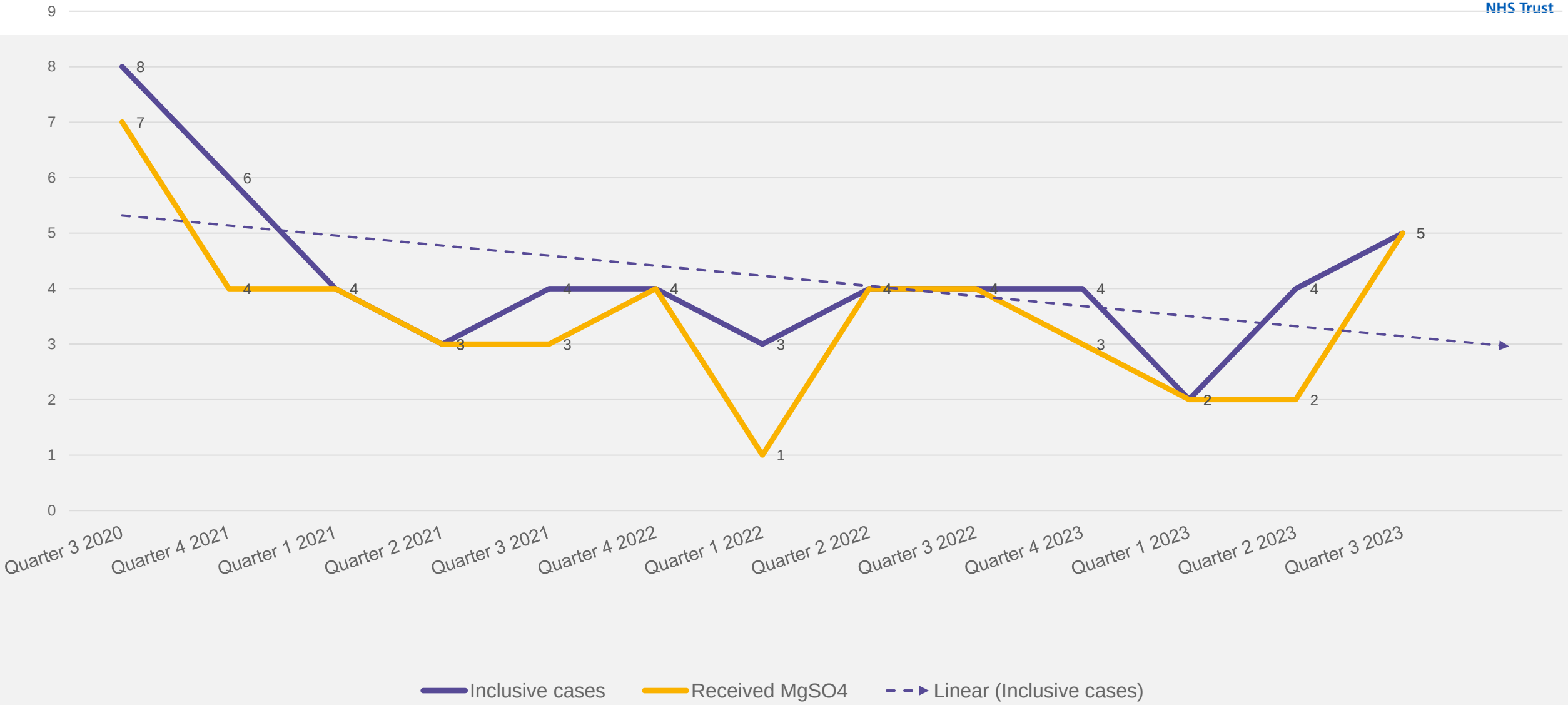
↑**100%** received MgSO4

Rolling annual average Q4 2023 – Q3 2023- 80%

National Ambition – minimum 80% / stretch 90% compliance

Antenatal Magnesium Sulphate (MgSO4) administer for neuroprotection (up to 29+6 weeks gestation)

The Shrewsbury and Telford Hospital NHS Trust



Magnesium sulphate– action plan

The Shrewsbury and Telford Hospital NHS Trust

Action	Target	Update	RAG rating according to local ambition
Review cases that were born at SaTH to detect any missed opportunities and cascade learning	Ambition Stretch of 90%	13/10/23 no missed opportunities identified in Q2 4/1/24 100% successfully administered – continue reviewing to achieve a stable >90%	
Share reviews with SaTH's Preterm Lead team	na	13/10/23 next meeting 12/1/24	na
Maternity staff update on Day 2- mandatory training	na	Occurs monthly – delivered by SBL Lead Midwife	na

4. Intrapartum antibiotics

The Shrewsbury and Telford Hospital NHS Trust

Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection.

<34 weeks

Cases in review period 7

Quarter 3 ↑**100%**

Rolling percentage **90%**

(Agreed local ambition min 80% - stretch 90%)

Review of cases 34 - 36+6 weeks (CNST year 5 – group to be considered)

Cases in review period 27

↔**79%**

Rolling percentage **79%**

Intrapartum antibiotics– action plan

The Shrewsbury and Telford Hospital NHS Trust

Action	Target	Update	RAG rating according to local ambition
Review cases that were born at SaTH to detect any missed opportunities and cascade learning	Ambition Stretch of 90%	13/10/23 no missed opportunities identified in Q2 5/1/24 Stretch ambition meet for <34/40. Continue to review and report quarterly.	
Share reviews with SaTH's Preterm Lead team	na	13/10/23 next meeting 12/1/24	na
Maternity staff update on Day 2- mandatory training	na	Occurs monthly – delivered by SBL Lead Midwife	na

5. Cord Management

The Shrewsbury and Telford Hospital NHS Trust

Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.

17 cases reviewed

Quarter 3 ↓**65%**

Rolling percentage **75%** (Q2- Q3 2023)

(CNST ambition – minimum 50%, stretch 75%)

6 cases either required immediate resuscitation or attempted but abandon < 60 seconds due to requiring resuscitation

6. Normothermia

Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth (on admission to the NNU).

Cases in review period 21

Quarter 3 ↔**81%**

Rolling percentage **74%** (Q2 – Q3 2023)

(CNST ambition – minimum 65%, stretch 80%)

Normothermia– action plan

The Shrewsbury and Telford Hospital NHS Trust

Action	Target	Update	RAG rating according to local ambition
Review cases that were born at SaTH to detect any missed opportunities and cascade learning	Ambition Stretch of 80%	5/1/24 Ambition met in last 2 individual quarters not as a rolling percentage. Continue to review and report quarterly.	
Share reviews with SaTH's Preterm Lead team	na	13/10/23 next meeting 12/1/24	na
Maternity staff update on Day 2- mandatory training	na	Occurs monthly – delivered by SBL Lead Midwife	na

7. Early maternal breast milk (MBM)

The Shrewsbury and Telford Hospital NHS Trust

Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.

Cases in review period 16

Quarter 3 ↓**75%**

Rolling percentage 77% (Q2 - Q3 2023)

(Local ambition min 50%, stretch 75%)

2 case declined in favour of artificially feeding

2 cases no documentation

Perinatal Optimisation Pathway Compliance (Composite metric)

The Shrewsbury and Telford Hospital NHS Trust

Implementation of optimisation interventions as a complete preterm perinatal optimisation pathway, including measurement and reporting of overall optimisation pathway compliance

Proportion of individual elements achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation)

Inclusive of; Place of birth, Antenatal corticosteroids, MgSO4, IV intrapartum antibiotic, Delayed cord clamping, Normothermia, MBM.

Total babies 16

Total relevant interventions 90

Total interventions achieved 67

Q3 ↑74%

Rolling percentage 70% (Q2 –Q3 2023)

(Locally agreed ambition min 50%, stretch 70%)

Perinatal Optimisation Pathway Compliance -action plan

The Shrewsbury and Telford Hospital NHS Trust

Action	Target	Update	RAG rating according to local ambition
Share reviews with SaTH's Preterm Lead team	Ambition Stretch of 70%	13/10/23 next meeting 12/1/24 5/1/24 Stretch ambition met (rolling percentage). Continue to review and report quarterly.	
Share with LMNS/ICB at quarterly review meeting	na		na
Maternity staff update on Day 2- mandatory training	na	Occurs monthly – delivered by SBL Lead Midwife	na
Share Preterm report with Maternity and Neonatal staff, Senior Leaders and Trust Board	Quarterly report		

Volume-Targeted Ventilation

For babies born below 34 weeks' gestation who need invasive ventilation

The Shrewsbury and Telford Hospital NHS Trust

Volume-Targeted Ventilation for babies born below 34 weeks' gestation who need invasive ventilation, the use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support is recommended.

This reduces the chance of death or bronchopulmonary dysplasia by 27% and intraventricular haemorrhage (grades 3–4) by 47% compared with pressure-limited ventilation modes.

Quarter 3 **100%**

7 babies required invasive ventilation

VTV is the Trust's primary method if invasive ventilation required

(Locally agreed ambition min 80%, stretch 90%)

Caffeine – peripartum neonatal care

The Shrewsbury and Telford Hospital NHS Trust

Caffeine For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth

Quarter 3 ↔**100%**

Rolling percentage **100%** (Q1 – Q3 2023)

(Locally agreed ambition min 85%, stretch 90%)

Neonatal Caffeine-action plan

The Shrewsbury and Telford Hospital NHS Trust

Action	Target	Update	RAG rating according to local ambition
Share reviews with SaTH's Preterm Lead team	Ambition Stretch of 90%	13/10/23 next meeting 12/1/24 5/1/24 Stretch ambition maintained. Monitoring to continue through quarterly reports	
Share with LMNS/ICB at quarterly review meeting	na	November 2023	na
Maternity staff update on Day 2- mandatory training	na	Occurs monthly – delivered by SBL Lead Midwife	na
Share Preterm report with Maternity and Neonatal staff, Senior Leaders and Trust Board	Quarterly report		

Singleton Preterm births – 16-23+6 weeks

The Shrewsbury and Telford Hospital NHS Trust

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a percentage of all singleton births:

a. In the late second trimester (from 16+0 to 23+6 weeks)

Cases in review period n=1007

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a. In the late second trimester (from 16+0 to 23+6 weeks)			
Number of births in review	1007		
Number of births not applicable	0	Total number births assessed	1007
Criteria	16+0 to 23+6 weeks	> 24 weeks	Total % of 16+0 to 23+6 weeks
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a. In the late second trimester (from 16+0 to 23+6 weeks)	9	997	0.9%

Nb – Includes 2nd Trimester medical terminations of pregnancy

Singleton Preterm births – 24-36+6 weeks

The Shrewsbury and Telford Hospital NHS Trust

7. The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a percentage of all singleton births:

b. Preterm (from 24+0 to 36+6 weeks).

Cases in review period n=1007

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: b. Preterm (from 24+0 to 36+6 weeks).			
Number of births in review	1007		
Number of births not applicable	0	Total number births assessed	1007
Criteria	24+0 to 36+6 weeks	Gestations ≥37 weeks	Total % of 24+0 to 36+6 weeks
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: b. Preterm (24+0 to 36+6 weeks)	64	943	6.4%

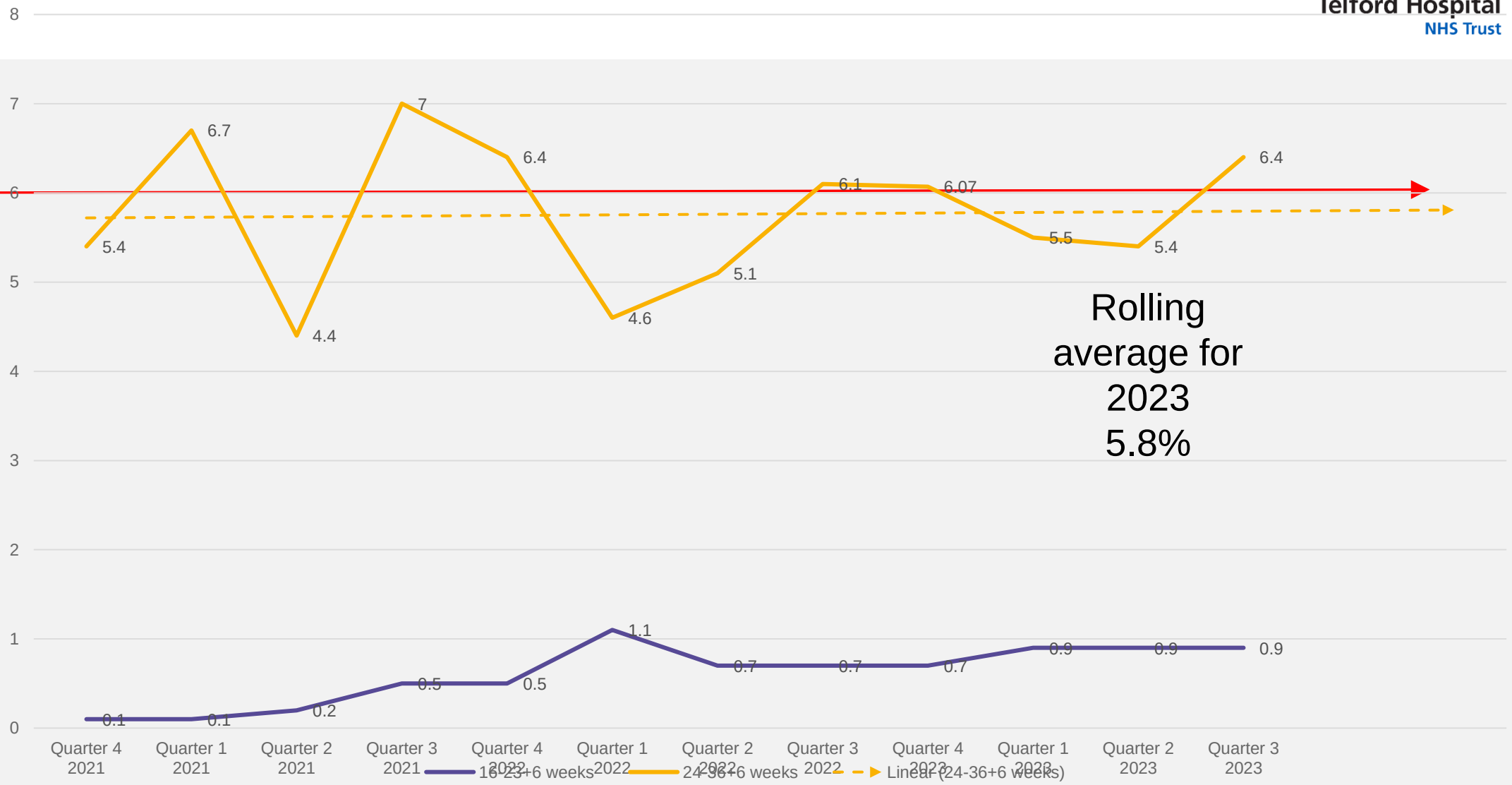
Accumulative Data

The following set of slides show accumulative standards data graphs commencing from 2020.

Incidence of preterm births at SaTH

The Shrewsbury and Telford Hospital NHS Trust

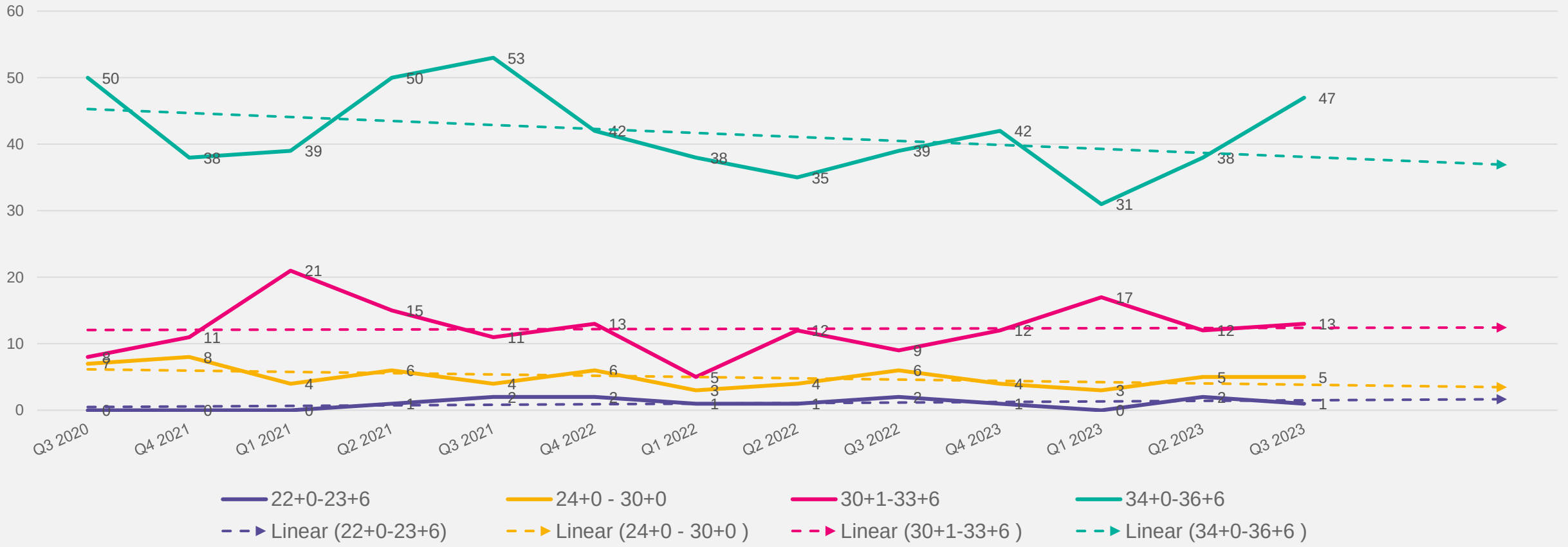
Government target of 6% by 2025



Rolling average for 2023 5.8%

Preterm singleton births
- Gestation breakdown

The Shrewsbury and Telford Hospital NHS Trust



Partnering · Ambitious
Caring · Trusted

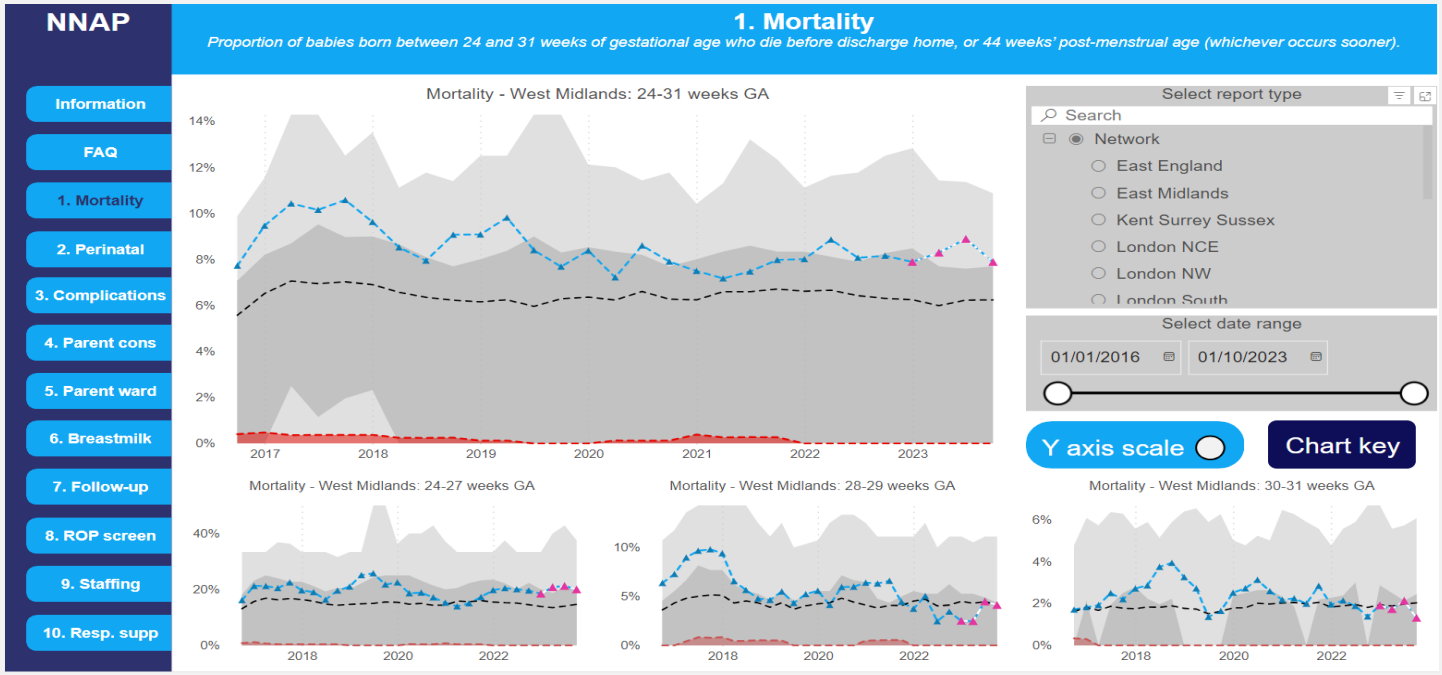
Our Vision: To provide excellent care for the communities we serve

SBLCBV3 Neonatal preterm outcomes indicators

The Shrewsbury and Telford Hospital NHS Trust

SBLCBv3/CNST year 5 outcome indicators

Mortality to discharge in very preterm babies. (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner).



Mortality data provided by NNAP demonstrates the West Midlands ODN has been consistently above the national proportion of around 6%.
In house review of babies born in SaTH using the NNAP criteria:
2022 -14.2% mortality rate (4 out of 28 babies)
2023 – 7.9% mortality rate (3 out of 38 babies, **NB** not finalised 11 babies Nov -Dec 2023 live but not yet reached 44 weeks post-menstrual age).

SaTH representatives are part of the West Midlands Preterm network. The network is actively reviewing mortality rates in the region and formulating strategies to improve the mortality proportion.

SBLCBV3 Neonatal preterm outcomes indicators

The Shrewsbury and Telford Hospital NHS Trust

SBLCBv3/CNST year 5 outcome indicators

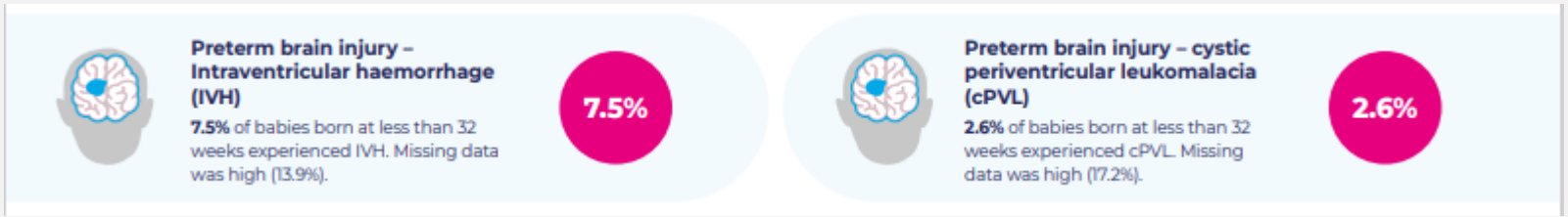
Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury:

Germinal matrix/ intraventricular haemorrhage (Grade 3-4 NNAP)

Post haemorrhagic ventricular dilatation

Cystic periventricular leukomalacia

NNAP 2022 national outcomes



SaTH 2022 NNAP data	10%	(3 babies of 30 reported (32 eligible))	3.4% (1 baby of 29 reported (32 eligible))
SaTH 2023 locally reviewed provisional data (using Neonatal and Maternity Badgernet/Clinical portal reports)	3.1%	(1 baby of 36)	3.1% (1 baby of 36)

NNAP 2023 not published

Reference

1. NHS England (2023) Saving Babies' Lives A care bundle for reducing perinatal mortality version 3 NHS England » Saving babies' lives: version 3
2. Antenatal Optimisation Toolkit | British Association of Perinatal Medicine (bapm.org)

APPENDIX 9

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
SaTH	Requires	Requires Improvement	Good	Good	Requires Improvement	Good

Maternity Safety Support Programme	Yes

QUARTER 3 - 2023					October	November	December	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths		0	1	1	100% compliance for reporting to MBRRACE within 7 working days and informing families that a PMRT review will take place and letters sent regarding the review
			Late fetal losses >22 wks		1	0	0	
			Neonatal Deaths		0	0	0	
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI			1	1	0	1 Referral reported to MNSI in October still pending decision (accept/decline) 1 Referral reported to MNSI in November 0 Referrals reported in December
3.	**SERIOUS INCIDENTS**	Findings of all SIs			1	0	0	There was one new SI reported in October - hospital acquired infection There were no SIs reported in November or December
3a.	**INCIDENTS**	The number of incidents recorded as Moderate Harm or above and what actions are being taken			2	3	3	All moderate harm or above incidents reviewed at weekly IRM (Incident Review Meeting). <u>Following MDT review, 2 incidents from October remain Moderate harm</u>: 1 x Baby transferred requiring cooling - MNSI referral awating decision 1 x a hospital acquired infection - investigated via divisional processes <u>3 incidents remain Moderate Harm for November</u> 1 x MNSI investigation in progress 1 x PMRT process 21/12/23 1 x no further investigation required 3 incidetns remained Moderate Harm for December At the time of writing, 2 additional incidents were awaiting final review/approval
3b.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Obstetricians	PROMPT	100%	100%	100%	A minimum of 90% compliance is required for PROMPT, NLS and Fetal Monitoring training as part of the Maternity Incentive Scheme reporting. The Education team continue to ensure that all medical staff are booked to attend FMT and where compliance does not meet the requirements, a process for escalation to the Medical Director is in place. A full review of the training guideline is in progress along with the 3 yr local training plan to meet the requirements of the CNST MIS Safety Action 8. International Recruitment is now in place to support the current workforce and 10 Internationally Educated Midwives have been recruited and are currently undertaking OSCE preparation for training.
				Fetal Monitoring	100%	100%	100%	
			Midwives	PROMPT	97%	99%	98%	
				NLS	94%	98%	94%	
				Fetal Monitoring	98%	98%	98%	
			Other Drs	PROMPT	92%	100%	96%	
				Fetal Monitoring	96%	100%	96%	
			Neonatal Nurses	NLS	100%	96%	100%	
			Anaesthetists	PROMPT	97%	97%	97%	
			WSAs/MSW	PROMPT	97%	91%	94%	

3c.	**STAFFING**	Minimum safe staffing in maternity services to include Obstetric cover on the Delivery Suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Maty Del Suite positive acuity	73%	54%	67%	NB: the D**el Suite positive acuity figure** is the 'end of month rate' reported each month on maternity dashboard and not the rolling 13 wk rate. The Delivery Suite co-ordinator was supernumerary on all occasions in October Antenatal and Postnatal areas are now reported as one area. Triage has been added to Delivery Suite. WSA fill rates for DS have been adjusted. AN and PN fill rates adjustment to templates for registered RM to meet 90/10 Birthrate Plus skill mix of RM and MSW. Obs Unit for Drs - Minimum safety staffing level always available on Delivery Suite.
			Maty 1:1 care in labour	100%	100%	100%	
			Fill rates Delivery Suite RM	86% day 87% night	88% day 81% night	89% day 69% night	
			Fill rates Postnatal RM Fill rates Antenatal RM	94% day 84% night	100% day 93% night	100% day 89% night	
			Obstetric Cover on D Suite	100%	100%	100%	
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP and UX system achievements		**UX system achievements so far this quarter**: **October**: •Review of communications around Healthy pregnancy Services •Diabetic meal options brought to Trust PEG •Rewrite of the dietary guide given to pregnant diabetic services users or those who develop gestational diabetes (in progress) •Inclusion of high BMI service users case studies into training content •Prescriptions for folic acid •New cycle started - Theme: Scanning and Screening The MNVP Facebook page shares positive messages fo feedback via their 'Thank you Thursday' posts. None were shared for October. The Trust's Maternity Information Hub Facebook page receives positive comments on The Colleague Spotlight posts. October saw one received praising medical and maternity staff 'an absolute credit to the maternity unit' describing her birth experience and care following a C Section. The Antenatal Ward, Delivery Suite and the Birth Reflections Service stand out in the number of service users providing positive feedback and should be commended. Utilising the FFT feature on BadgerNet is also an option which may improve and increase our response rates. **November**: **MNVP - Feedback** • 36 responses for Brith refelctions survey, main themes around wait times for appoitments, need to travel, communication, compassion, time (some patients felt rushed), excellent service. • Neonatal Hot Meals survey launched. • Quarterly feedback surey to be presented at MNVP Hub 21st December **MNVP - Key Projects** • UX theme, scanning and screening • Incident and complaints process working with Governance Team • Training for preceptorship midwives,international midwives • 15 Steps visit to Wrekin MLU 18th December **MNVP - Engagement** Bereavement Focus Group, Baby Stop, Bounce & Rhyme Wellington/Newport **December** To note - there are no further updates for the UX system, as this has now been stood down and superseded by the Patient Experience Group.			
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*		No Walkabout	PRH Scanning and Outpatients Clinic	No Walkabout	'Our Staff Said, We Listened' feedback posters with updates for staff from the walkabouts are distributed widely via email and on display
6.	**EXTERNAL**	Requests from an external body (MNSI/NHSR/CQC or other organisation) with a concern or request for immediate safety actions made directly with Trust		0	0	0	The last safety recommendation reported by MNSI was in 2022 and this is related to an aspect of escalation for medical review.

7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust	0	0	0	To note - there have been no Regulation 28s since May 2021.
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10	✓	✓	✓	**No investigations have been published in October or November, and there are no safety recommendations**. There have been no safety recommendations in any reports published in the last year. The last was made in April 2022. 50% of SaTH investigations to date have had no safety recommendations from MNSI compared to national figure of 15%
9.	**ECLAMPSIA**	Number of women who developed eclampsia	0	0	0	Zero cases reported for Q4, Q1, Q2 and Q3 2023
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment						44.3% for Maternity Services published 2023
Proportion of specialty trainees in Obs & Gynae responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours						Reported annually - 87% *(source GMC National Trainees Survey 2022)*