The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

April 2024

Maternity Transformation Update

Presenters:

Annemarie Lawrence – *Director of Midwifery*

Carol McInnes – *Divisional Director of Operations*

Mei-See Hon – *Clinical Director for Obstetrics*

Background: The Independent Maternity Review

The Shrewsbury and Telford Hospital NHS Trust

- The Independent Review of Maternity Services at the Trust, chaired by Mrs Donna Ockenden, examined cases arising mainly between 2000 and 2019, involving 1,486 families and the review of 1,592 clinical incidents.
- The first Ockenden report was published in December 2020, and was followed by the final report, which was published in March 2022. These reports highlighted significant failings in maternity care at the Trust.

References

Ockenden Review (December 2020), Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust.

Ockenden Review (March 2022), findings Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our Final Report

Background: The Independent Maternity Review

The Shrewsbury and Telford Hospital NHS Trust

- The Review found repeated failures in the quality of care and governance at the Trust, as well as failures of external bodies to monitor the care provided effectively. These failures included there not being enough suitably experienced staff, a lack of ongoing training, a lack of investigation and governance at the Trust, and a culture of not involving or listening to the women and families involved.
- The Chief Executive gave an unreserved apology to the women and families affected by the review, along with the commitment to implement all the actions arising from the Review, which was later endorsed by the Board of Directors.
- The Trust owes it to those families it failed, and to those that it cares for today, and in the future, to continue to make improvements to provide the best possible care for the communities it serves.

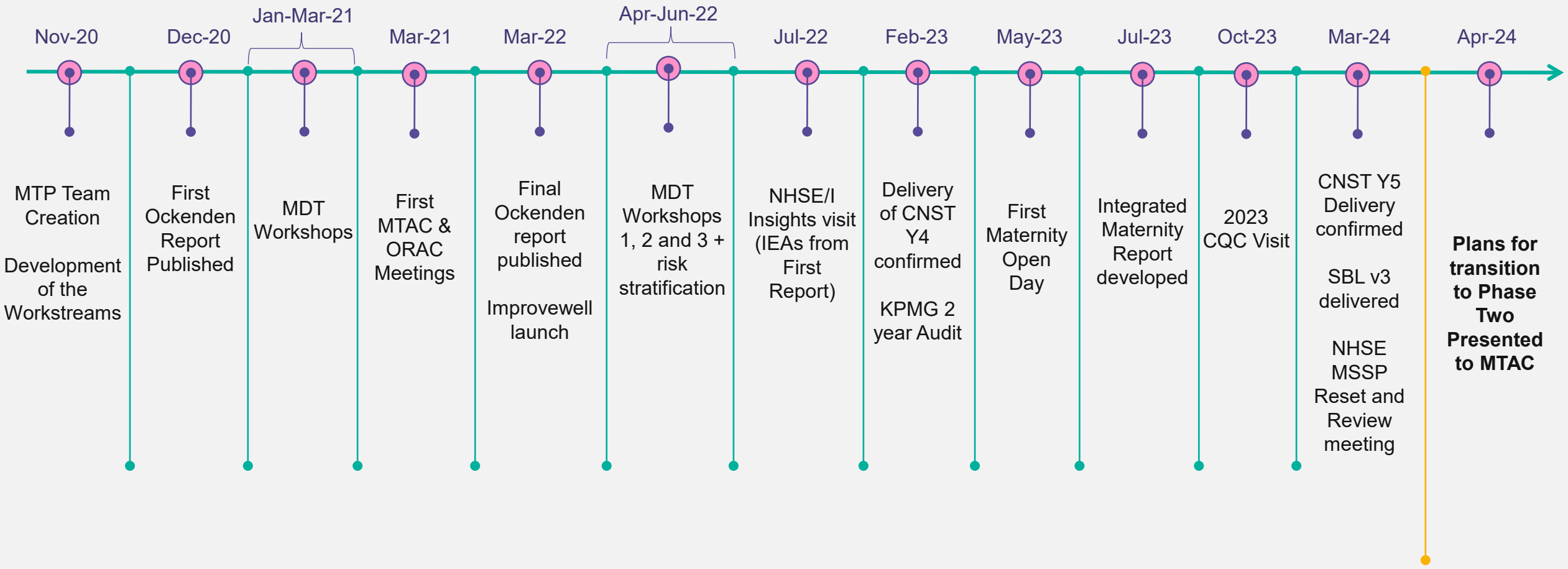
Background: The Independent Maternity Review

The Shrewsbury and Telford Hospital NHS Trust

- The Board of Directors established the Ockenden Report Assurance Committee (ORAC), as a committee of the Board to obtain and provide assurance in relation to the delivery, evidence, sustainability, and impact of the implementation of the 210 actions arising from the Ockenden Reports. This was also part of a suite of actions to improve accountability and transparency to the public for this improvement work.
- In establishing this Committee, the Board of Directors was mindful of the "call to action" signalled in the Ockenden Report that there must be an end to investigations, reviews and reports that do not lead to meaningful change.
- It was envisaged that ORAC would always be time-limited, providing good progress had been made in implementing, evidencing and assuring the required levels of change and transformation of maternity services.
- ORAC commenced on 25 March 2021. There have been 26 meetings of the committee, and today's meeting is the final meeting.
- Transitional arrangements for the ongoing governance and assurance of the actions are described later in this presentation.

High-level Timeline of Key Events

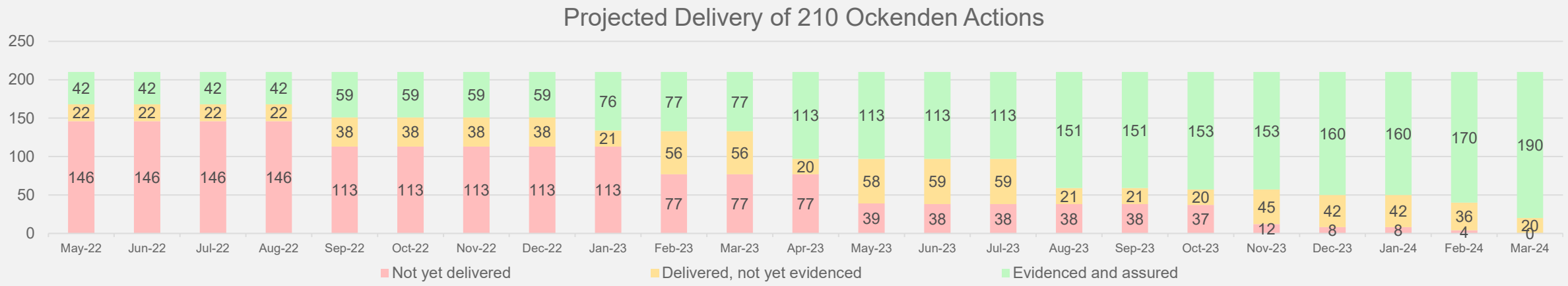
The Shrewsbury and Telford Hospital NHS Trust

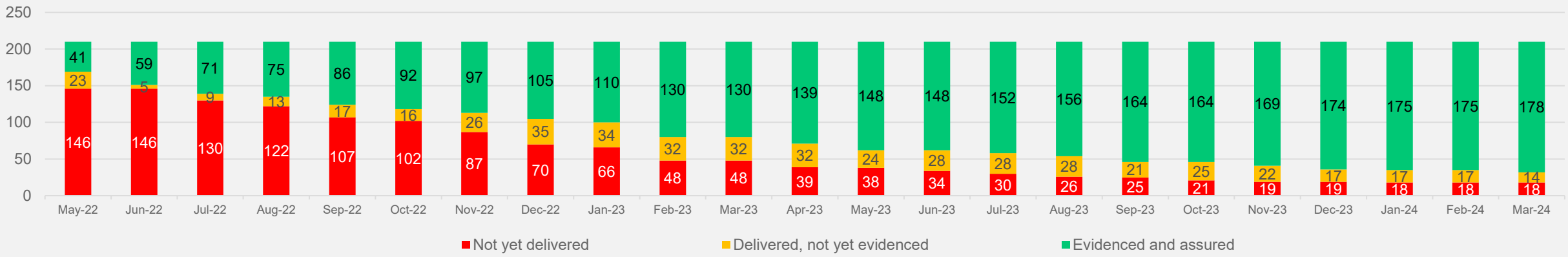


Ockenden Position

Assurance - Projected vs. Actual Delivery

The Shrewsbury and Telford Hospital NHS Trust

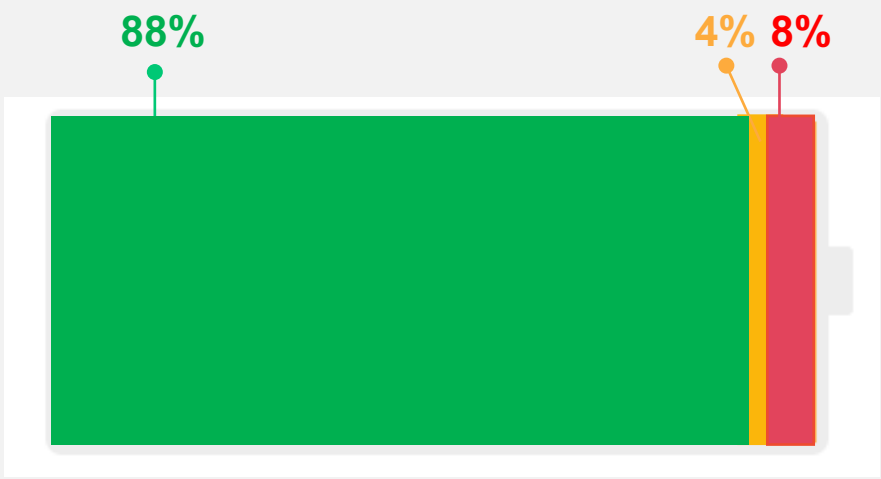




Ockenden Reports - Delivery Rates – First Report

The Shrewsbury and Telford Hospital NHS Trust

First Report - Delivery Battery



48/52 (92%) actions implemented

- 46 actions (88%) ‘Evidenced & Assured’
- 2 actions (4%) ‘Delivered, Not Yet Evidenced’
- 4 actions (8%) ‘Not Yet Delivered’

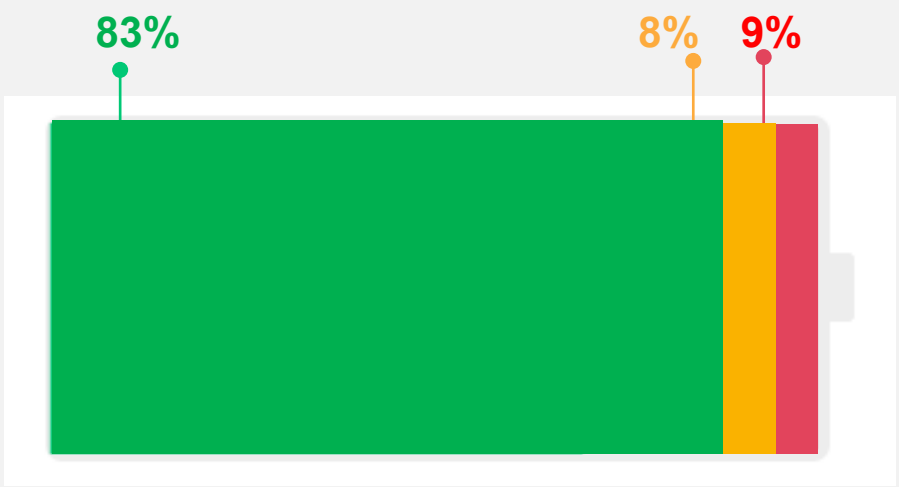
First Report – Progress Battery

- 46 actions (88%) ‘Complete’
- 4 actions (8%) ‘On Track
- 2 action (4%) ‘Descoped/On Hold’

Ockenden Reports - Delivery Rates – Final Report

The Shrewsbury and Telford Hospital NHS Trust

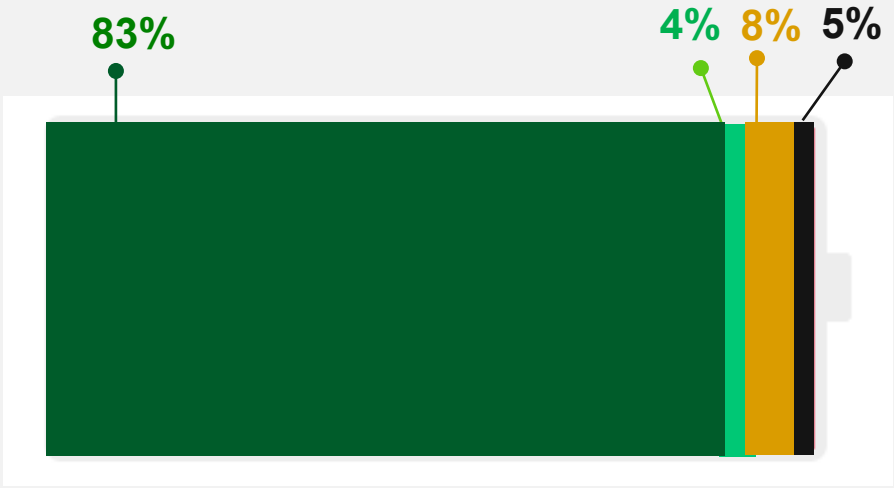
Final Report - Delivery Battery



144/158 (91%) actions implemented

- 132 actions (83%) ‘Evidenced and Assured’
- 12 actions (8%) ‘Delivered, Not Yet Evidenced’
- 14 actions (9%) ‘Not Yet Delivered’

Final Report – Progress Battery



- 132 actions (83%) ‘Complete’
- 6 actions (4%) ‘On Track’
- 12 actions (8%) ‘At Risk’
- 8 actions (5%) ‘Descoped/On Hold’

Outstanding Actions

Red and Amber Actions from the 210 Actions (Outstanding)

The Shrewsbury and Telford Hospital NHS Trust

18 Red Actions:

Ock1: 4 reds (3 on track,1 descoped)

Ock2: 14 reds (3 on track, 7 descoped, 4 at risk)

14 Amber Actions:

Ock1: 2 ambers (1 on track, 1 descoped)

Ock2: 12 ambers (3 on track, 1 descoped, 8 at risk)

32 actions

On Track	10
Currently Off Track	0
At Risk	1
At Risk *pending business case approval*	11
Descoped	10

On Track Actions

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Delivery	Progress	Deadlines
IEA 2.1 (First Report)	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Not Yet Delivered	On Track	Aug-24 Dec-24
IEA 2.2 (First Report)	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.	Not Yet Delivered	On Track	Aug-24 Dec-24
LAFL 4.73 (First Report)	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.	Delivered, not yet Evidenced	On Track	Dec-24
LAFL 4.100 (First Report)	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.	Not Yet Delivered	On Track	May-24 May-25

On Track Actions

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Delivery	Progress	Deadlines
LAFL 14.1 (Final report)	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.	Not Yet Delivered	On Track	Apr-24 Apr-24
LAFL 14.2 (Final report)	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	Delivered, not yet Evidenced	On Track	Jun-24
LAFL 14.38 (Final report)	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.	Delivered, not yet Evidenced	On Track	Jun-24
LAFL 14.53 (Final report)	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.	Not Yet Delivered	On Track	Jun-24 Dec-24
LAFL 14.55 (Final report)	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.	Not Yet Delivered	On Track	Jun-24 Dec-24
LAFL 14.62 (Final report)	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.	Delivered, not yet Evidenced	On Track	Mar-25

‘At Risk’

ID	Description	Delivery	Progress	Risk Score
IEA 1.7 (Final Report)	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.	Delivered, Not yet Evidenced	At Risk	4

This action is currently “At Risk” whilst a plan is being created to allow for the release of staff to attend the additional training required by the released National Coordinator Development Programme. Timelines are expected to be presented at the next MTAC.

Ockenden Business Case

- Eleven actions are ‘at risk’ awaiting additional, recurrent, investment to be able to deliver and embed them.
- Discussions are underway with both local system and regional colleagues regarding the funding required to fully deliver the identified actions.
- Additional information has been requested by system leads regarding the quality and equality impact assessment associated with the business case that has been produced, following publication of the final report, which has been provided.
- The actions affected are summarised in the following tables.
- Where possible, mitigating actions are in place to reduce the risk while we await the decision regarding funding. However, to note, sustainable delivery of these actions cannot be achieved without the requested funding.

Actions Outlined within Business Case

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Delivery	Progress	Risk Score
IEA 4.3 (Final Report)	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Not Yet Delivered	At Risk	12
IEA 8.1 (Final Report)	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.	Not Yet Delivered	At Risk	20
IEA 11.1 (Final Report)	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.	Delivered, not yet Evidenced	At Risk	9
LAFL 14.32 (Final Report)	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	Delivered, not yet Evidenced	At Risk	16

Actions Outlined within Business Case

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Delivery	Progress	Risk Score
LAFL 14.52 (Final Report)	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.	Not Yet Delivered	At Risk	15
LAFL 14.57 (Final Report)	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.	Delivered, Not yet Evidenced	At Risk	6
LAFL 14.59 (Final Report)	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.	Delivered, Not yet Evidenced	At Risk	9
IEA 14.8 (Final Report)	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.	Not Yet Delivered	At Risk	8

Actions Outlined within Business Case

The Shrewsbury and Telford Hospital NHS Trust

ID	Description	Delivery	Progress	Risk Score
IEA 1.2 (Final Report)	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.	Delivered, Not yet Evidenced	At Risk	5
IEA 12.2 (Final Report)	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum	Delivered, Not yet Evidenced	At Risk	12
IEA 12.3 (Final Report)	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	Delivered, Not yet Evidenced	At Risk	12

Descoped Actions

The Shrewsbury and Telford Hospital NHS Trust

Descoped actions were reviewed at Mar-24 MTAC.

ID	Description	Delivery	Position
IEA 1.4 (First Report)	An LMS cannot function as one maternity service only.	Not Yet Delivered	Due for quarterly review at Jun-24 MTAC
IEA 2.4 (First report)	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.	Delivered, Not yet Evidenced	
IEA 1.1 (Final Report)	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.	Not Yet Delivered	
IEA 1.4 (Final Report)	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	Not Yet Delivered	
IEA 1.11 (Final Report)	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.	Not Yet Delivered	

Descoped Actions

The Shrewsbury and Telford Hospital NHS Trust

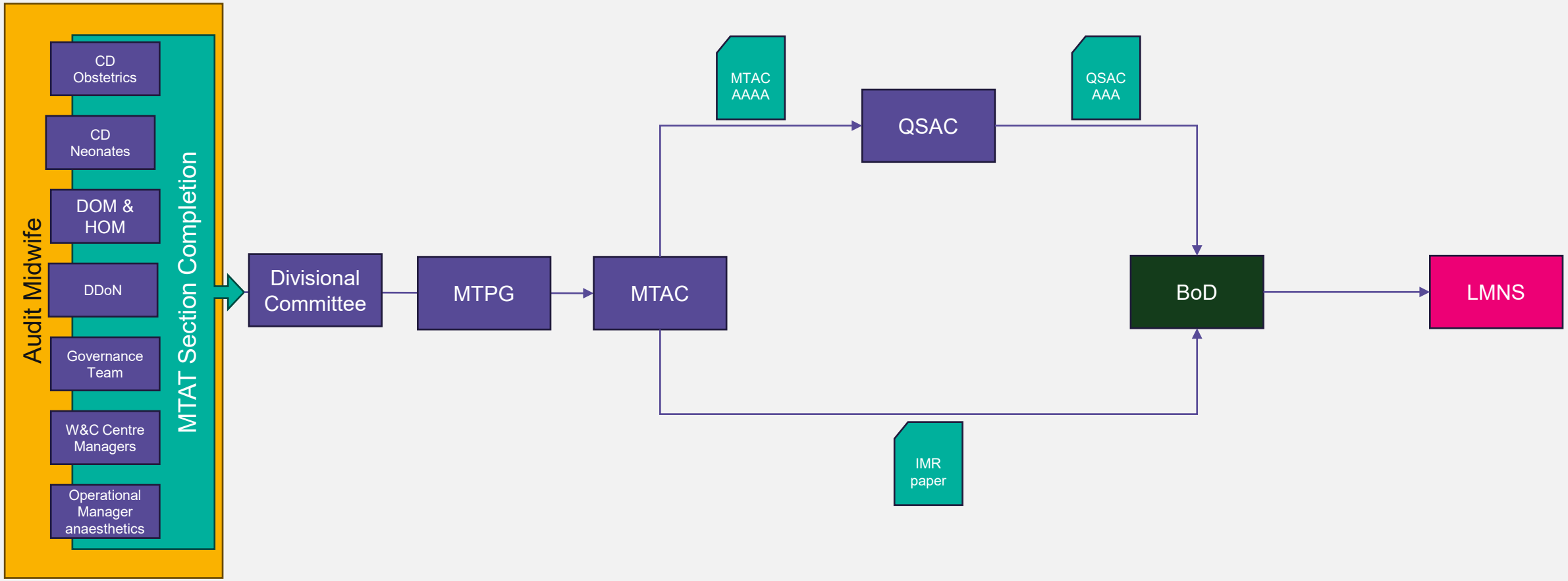
ID	Description	Delivery	Position
IEA 6.1 (Final Report)	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death	Not Yet Delivered	Due for quarterly review at Jun-24 MTAC
IEA 11.4 (Final Report)	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.	Not Yet Delivered	
IEA 14.4 (Final Report)	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.	Delivered, not yet evidenced	
IEA 14.5 (Final Report)	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	Delivered, not yet evidenced	
LAFL 14.64 (Final Report)	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.	Not Yet Delivered	

Maternity Transformation Assurance Tool (MTAT)

Maternity Transformation Assurance Tool (MTAT)

- How do we make sure that a green action remains green? By using a bespoke Maternity Transformation Assurance Tool (MTAT).
- The MTAT is group of audits/ reviews which are linked to the Ockenden actions. The aim is to utilise the tool on a quarterly basis to ensure that the action remains ‘evidenced and assured’ and does not revert to ‘Not Yet Delivered’.
- The MTAT will be included within the Maternity Forward Audit Plan, which is presented and reviewed at Maternity Governance on a monthly basis.
- A governance model has been agreed at Apr-24’s MTAC, illustrating the assurance committees and governance forums that the MTAT outcomes would be channelled through. A SOP will be developed to ensure the tool is used appropriately.

Governance Model



CNST Update

CNST Update

The Shrewsbury and Telford Hospital NHS Trust

- The Board Declaration for CNST MIS Year 5 was submitted at the end of January 2024 stating the Trust had implemented all 10 Safety actions following a rigorous review by senior and executive leadership.

- Full compliance has now been confirmed for all actions and has been externally validated.

- Additionally, the Service has now achieved 100% implementation of the Saving Babies' Lives Care Bundle v3. (70% implementation was required to achieve CNST along with the assurance the Service was on track for full implementation by March 31st) It is currently the only service in the Midlands to have done so.

- Guidance for year 6 of the Scheme was published this month and work has already started to ensure compliance is achieved again this year.

Thank You.
Any Questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

April 2024

Maternity Transformation: A Retrospective

Presenters:

Annemarie Lawrence – *Director of Midwifery*

Carol McInnes – *Divisional Director of Operations*

Mei-See Hon – *Clinical Director for Obstetrics*

Improvements Linked to the Delivery of Ockenden Actions

Community Engagement

First Ockenden Report Summary of Improvements: IEAs

The Shrewsbury and Telford Hospital NHS Trust

IEA 1: Safety	IEA 2: Women's voice	IEA 3: Learning	IEA 4: Complex Pregnancies	IEA 5: Risk Assessments	IEA 6: Fetal Monitoring	IEA 7: Informed Consent
Data/ Dashboards	Maternity Voice Partnership (MVP)	Training	Clear Pathways	Personalised Care Meetings	Fetal Monitoring Leads and Training	Accurate information
○ Dashboard/ Data sharing ○ Robust reporting for data oversight/ sharing ○ LMNS Buddying up agreement ○ PSSI reports shared with LMNS	Independent Senior Advocate Role created ○ NED co-chairing safety champions ○ CQC working with MNVP ○ 15 Steps embedded ○ MNVP presence for B8a and above recruitment	○ PROMPT training ○ Multidisciplinary Ward rounds ○ Funding allocated strictly for training ○ CCF in place ○ Incidents investigated and learning shared timely	○ Named consultant leads ○ Guidelines benchmarked against National standards ○ Clinical risk assessments at every appointment ○ Maternal medicine specialist clinics in place	○ Use of Badgernet standardising risk assessment ○ Personalised care planning meetings for individualised care ○ Clear pathways for changes in risk assessments	○ Fetal monitoring leads in place ○ Mandatory Electronic Fetal monitoring training ○ Evidenced delivery of Saving Babies' Lives Care Bundle v1, 2 and 3	○ Information leaflets and website updated ○ Maternity personalised care and support planning meeting ○ Birth Preferences Cards embedded Bereavement cards in development

First Ockenden Report Summary of Improvements: LAFLs

The Shrewsbury and Telford Hospital NHS Trust

Theme 1: Maternity Care

Specific Improvements

- Accurate information provided (leaflets, website, videos, etc.)
- Clinical governance team well-resourced
- Consultant-led ward rounds
- Lead midwife and obstetrician for bereavement care
- National Bereavement Care Pathway adopted

Theme 2: Maternal Death

Avoiding Maternal Death

- Audits against escalation policy
- Women with pre-existing co-morbidities seen by specialist MDT
- Named consultant for high-risk women
- Early referrals to Maternal Medicine Specialist Centre
- All guidelines benchmarked against National standards

Theme 3: Obstetric Anaesthesia

Anaesthetic Improvements

- PROMPT attendance and teaching
- Ward round attendance
- Guidelines reviewed and audited
- Escalation to the on-call consultant guideline
- Quality improvement methods in place to improve service
- Learning from incident investigations alongside maternity colleagues

Theme 4: Neonatal Services

Neonatal Service Improvements

- Neonatologists visiting other NICUs for learning
- Medical and Nursing notes combined
- Neonatal exception reports shared with Network
- Action plan in place to align with BAPM standards
- Plan in place for ANNPs to rotate to other units

Final Ockenden Report Summary of Improvements: IEAs & LAFLs

The Shrewsbury and Telford Hospital NHS Trust

Pillar 1: Antenatal care	Pillar 2: Intrapartum care	Pillar 3: Postnatal care	Pillar 4: Governance	Pillar 5: Workforce	Pillar 6: Learning	Pillar 7: Neonates
Specific Improvements	Specific Improvements	Specific Improvements	Systems and Processes	People and Culture	Training	Accurate information
○ Multiple pregnancy ○ specialist recruited ○ My Birth Place choices leaflet ○ Investment in Diabetes Service ○ Guidelines reviewed and benchmarked against NICE ○ Multiple Pregnancy ○ Diabetes ○ Gestational Hypertension ○ Preterm Birth ○ EFM ○ In Utero Transfer ○ Fetal Growth ○ Assessment	○ 24/7 consultant presence on labour ward ○ Induction of labour audits ○ New CTG telemetry machines purchased ○ Staffing papers: red flags and supernumerary status ○ Established to ○ BirthRate Plus ○ CQC Maternity Survey evidenced improvements to intrapartum care	○ Follow up appointments ○ Psychological ○ Support ○ Patient feedback audits ○ Postnatal readmissions audit ○ National Bereavement Care Pathway followed ○ Birth Reflections service in place	○ Named consultant leads ○ Guidelines benchmarked against National standards ○ Clinical risk assessments at every appointment ○ Maternal medicine specialist clinics in place	○ Culture work ○ underway ○ Divisional workforce plans completed ○ DS and Triage coordinator development programmes ○ Mentors identified for B7 and above midwives ○ Labour Ward Coordinators 360 assessments ○ Psychologist ○ Team in place	○ PROMPT ○ EFM and emergency skills training ○ Preceptorship programme ○ Behaviours and ○ Values training ○ Civility, human factors and leadership training ○ Complaints ○ handling training ○ Delivery of CNST SA 8 ○ Part of CCF Pilot	○ Neonatal workforce plan ○ TNA for ANNPs ○ Increase in numbers of Qualified in Speciality Nurses to align with BAPM standards

Community Engagement

Community Engagement

Develop Good Relationships

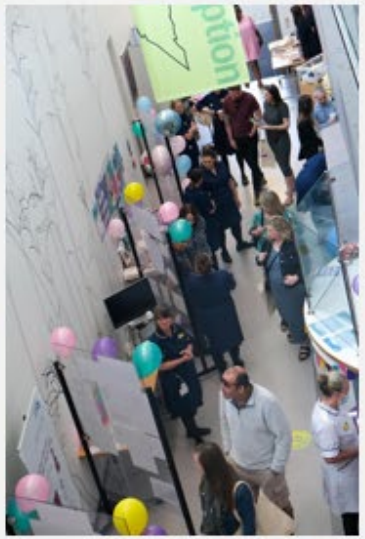
Executives

Integrated Care System
Shropshire, Telford and Wrekin

System partners

Family Engagement

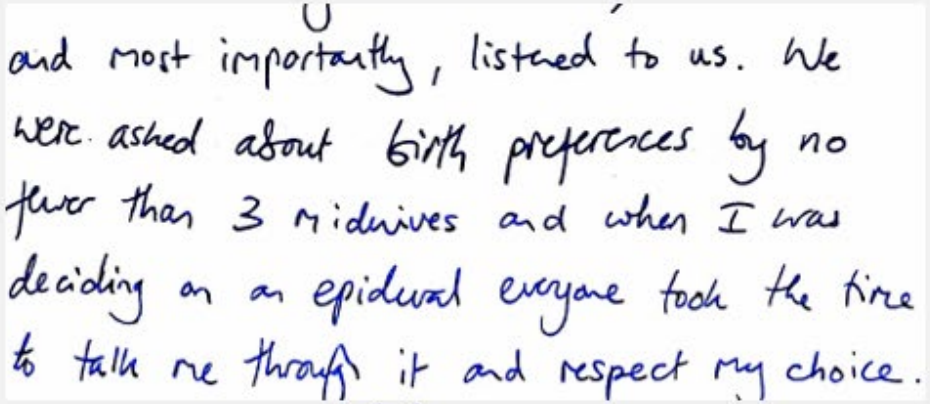
The Shrewsbury and Telford Hospital NHS Trust



What Matters Most

The Shrewsbury and Telford Hospital NHS Trust

I suffered with mental health problems with both my babies and Hannah went above and beyond to make sure I was seen regularly and comfortable with everything. Hannah genuinely cared and always listened to me, it made me feel so relaxed and I loved going to my appointments.



Consultant [redacted] who listened to my concerns prior to birth and never once made me feel like my feelings were invalid. She provided me with information around the different types of birth available to me so that I was able to make an informed choice.

"I'm currently 20 weeks pregnant and had my 20 week scan on 3 May. The two ladies who did my scan, one was in training, were so lovely and really were just everything I could have asked for.

I was feeling anxious before my scan due to some bleeding and both ladies made me feel so reassured and at ease, I honestly cannot compliment them enough. I wish I'd said more after the scan which is why I'm writing this feedback, they are honestly an asset to your team and I just wish every woman could have them do their scans because they were patient, they checked in with me regularly, they were excited over baby, it was just lovely and didn't feel as 'routine' as possibly some other scans have felt. They really made it feel like a special day and a special experience and I'm just really grateful - Lois"

Maternity Open Days

- In light of the findings from the Ockenden report, there is a need to regain the confidence of the communities we serve in our maternity services.
- As part of this, we decided to hold a first open day in May 2023 to create an opportunity for our communities to engage with our staff to learn about some of the improvements we have made and are making to our services.
- Following the success of the first event, it was agreed it would be held twice a year going forward.
- Our second Open Day was held on the 23rd of March 2024.
- Planning for the next event is underway for September 2024.

**People in the photographs shown have given their consent for these pictures to be used.*

On the Day

The Shrewsbury and Telford Hospital NHS Trust

We welcomed over **160 visitors** on the day. The event was supported by our staff, the MNVP and other colleagues from the Trust and System.

The following stalls were available for people to visit:

- Antenatal and Postnatal
- Labour and Birth
- Community Services
- Maternity and Neonatal Voices Partnership
- Perinatal Pelvic Health
- Badgernotes
- Saving Babies Lives
- The Breastfeeding Network
- Chaplaincy
- Patient Experience
- Health Visitors
- Community Engagement

Tours

- Visitors were able to join a tour of our wards and units, they were again very popular.

- This included our Training Suite where our education team demonstrated some clinical simulations, and gave future service users an insight into how our teams respond to emergencies

Feedback

The Shrewsbury and Telford Hospital NHS Trust

- Feedback on the day was overwhelmingly positive with families sharing they had found their visit helpful, that they had enjoyed meeting our staff, and that being able to come and visit our facilities had helped them feel more prepared.
- Leaflets linking to a survey were handed out on the day to collect insight on what went well and what we could improve on, it has been very positive.

What did you most enjoy about the day?

How friendly and welcoming all the staff were! It made me feel like I would be really looked after and could speak to anyone about mine and my baby's care. Thank you all.

Thank you all as it must take a lot of effort and planning to put this kind of event on. I was quite nervous about attending but was put at ease straight away by how friendly all the staff were. Instantly welcoming, smiley and happy to answer any questions. I really hope more of these sorts of events are put on over the year as it is a great way to access a lot of information and speak to lots of friendly staff. You should all be really proud. Thank you

What could we do better?

Maybe touch a little more on multiple births.

The Programme, viewed by our staff and service users

The Shrewsbury and Telford Hospital NHS Trust

Video

Key Improvements from our Midwifery Leadership Team

The Shrewsbury and Telford Hospital NHS Trust

Video

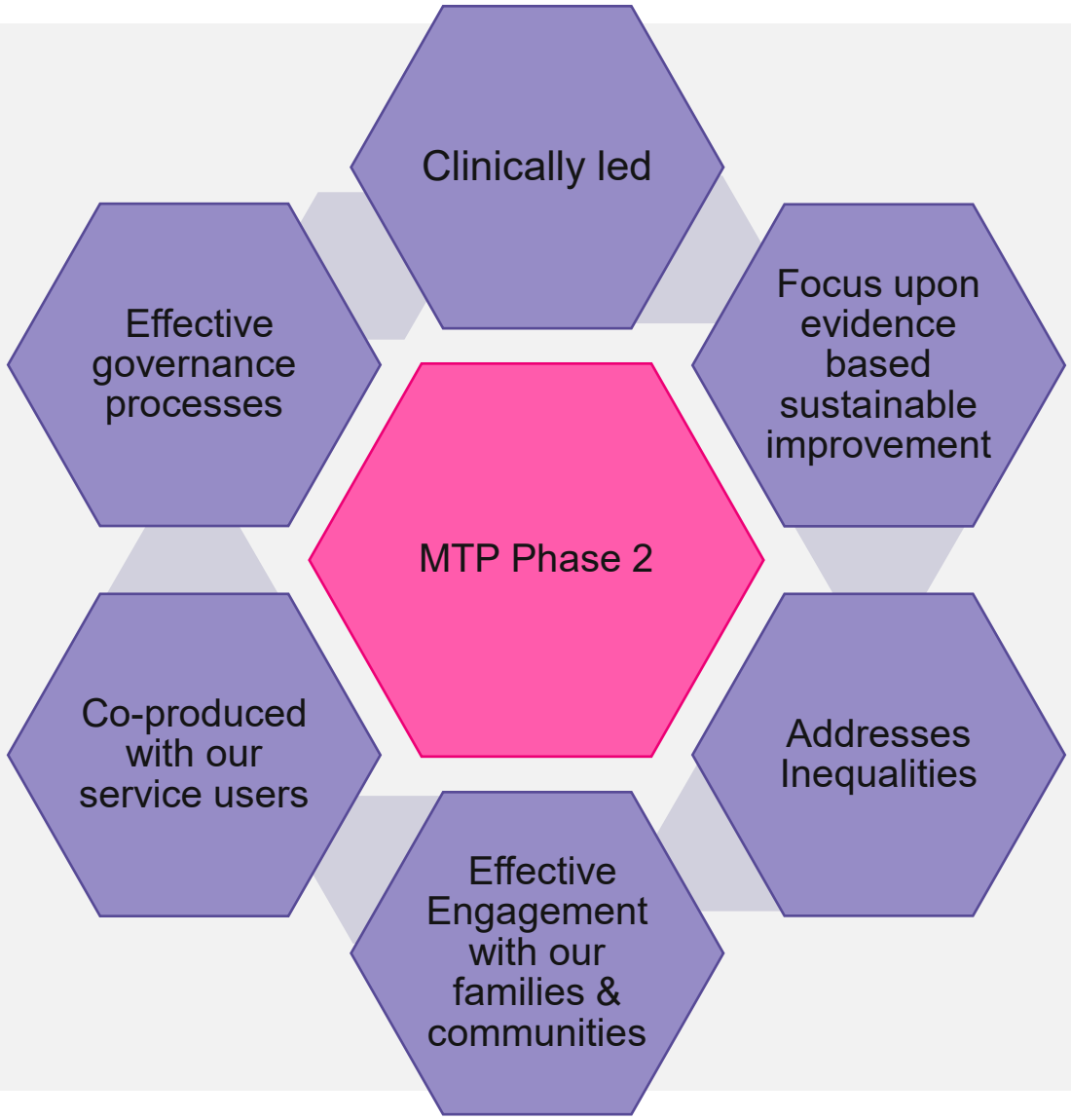
MTP Phase Two

Background & Context

- Implementing, evidencing and sustaining delivery of the actions has been the priority focus for the MTP
- As the majority of these actions have now been delivered, it is timely to review and plan for the next phase of improvement work for the MTP
- In planning for the next phase of our improvement work, the senior team have mapped any key national plans required for delivery, local improvement plans that are considered to be a priority by our clinical teams and what is considered ‘business as usual’ for a division aligned with work that can be considered ‘transformative’
- The following slides provide a summary of the proposed approach to the next phase of work for the MTP

Programme Scope

Planning for Phase 2 – Our Ambition



3 Year Delivery Plan – the Golden Thread

The Shrewsbury and Telford Hospital NHS Trust

Theme 1: Listening to and working with women & families with compassion

Theme 2: Growing, retaining & supporting our workforce

Theme 3: Developing & sustaining a culture of learning, safety & support

Theme 4: Standards & Structures that underpin safer, personalised, equitable care

MTP Phase 2 Proposed Scope

In addition to the single delivery plan, further to the completion of a mapping exercise of the current reporting arrangements within the division for maternity services, the following items have been identified as 'transformative' pieces and are therefore proposed for inclusion in scope as phase 2 of the MTP:

Item
Continued delivery of first and final Ockenden reports
MTAT quarterly review
Equity & Equality Delivery Plan
Black Maternal Health Action Plan
CQC Improvement Action Plan (May 2024)
CQC Maternity Survey Action Plan
Maternity Community Service Divisional Review Action Plan
Divisional Cultural Improvement Plan
CNST Delivery Plan

- Any in year external visits/reports and any other miscellaneous/new actions that transpire will be considered initially via MTG.
- A proposal for allocation of any new work to an identified workstream will then be submitted to MTAC.

Proposed Workstream Allocation

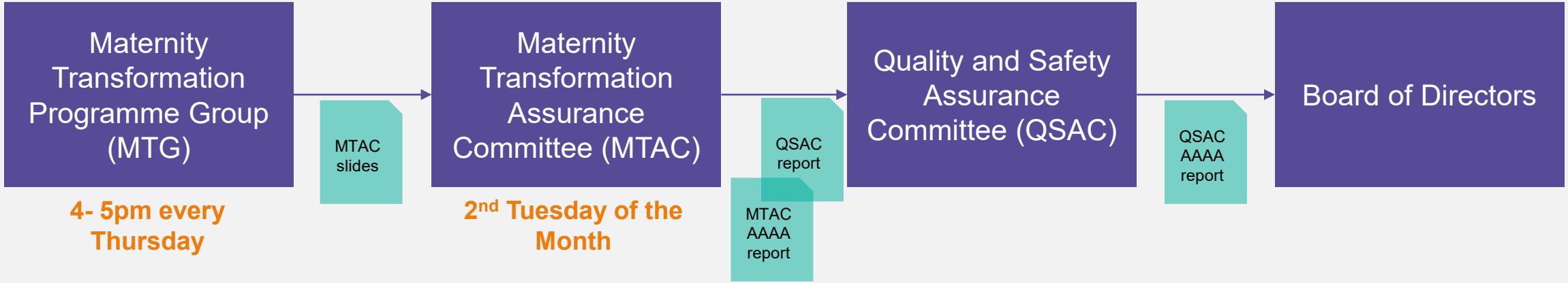
MTP Phase 2 Proposed Workstreams

Ref	Workstream	Aligned Delivery Plans
1.	Clinical Practice	• Continued Delivery of Ockenden Report LAFL's & IEA's • CQC Maternity Survey Action Plan • Black Maternity Health Action Plan • Equity & Equality Delivery Plan
2.	Governance, Assurance & Delivery	• CQC Maternity Improvement Action Plan (May 2024) • CNST Delivery Plan • Maternity & Neonatal Single Delivery Plan • Maternity Community Service Divisional Review Action Plan • MTAT Quarterly Review (any identified areas of concern to be fed into clinical practice workstream)
3.	People & Culture	• Divisional Cultural Improvement Plan *(incorporating – the perinatal survey action plan and staff survey improvement plan for maternity & neonatal services)*

Meeting Structure

Governance Structure

The Shrewsbury and Telford Hospital NHS Trust



4- 5pm every Thursday

- Divisional oversight of plan
- Workstream delivery overview
- 'Sprint' actions reviewed
- Evidence reviewed to take to MTAC
- Exception reports reviewed
- Finance/operational aspects discussed

2nd Tuesday of the Month

- Executive led
- External stakeholders as part of the membership
- MTP updates presented
- MTP action status proposals accepted/rejected

- Report received by QSAC from MTAC regarding status implementation with any exceptions noted
- Escalation point for any key issues

- Oversight of MTP

The overarching purpose of the governance structure is to be able to ensure processes are in place for independent assurance of the divisions improvement and transformational work

And Finally…

What drives our Service

Service user Kara shared her thanks to our teams following the birth of her baby boy.

“In 2020 I had a traumatic birth with my son. This left me distrusting unconfident that I could ever deliver a baby safely.

When I arrived at hospital to have my second baby, I was greeted by the lovely midwife, Becky G. She put on projector lights and had music playing ready for our arrival which put me at ease right away. The room we were put into was gorgeous, cosy and relaxing! Becks was so warm and welcoming and I knew I was in safe hands which meant a lot to me.

Unfortunately for everyone there with me, I get very loud on gas and air but Becky reassured me through the whole 4 hours of labour and encouraged me when I doubted myself. My mental health birth plan was read and completely respected. I felt so safe and listened to. Becky is an amazing midwife with so much empathy and compassion. At what felt like such a vulnerable time for me, she empowered me and restored my confidence and trust in myself. She is someone I will forever be grateful for and I will never forget. I’m sure she will also never forget me and the things that came out my mouth that night!

We would also like to thank the medical student, Kieran C, who was present during the entire labour & birth. You were on it to find me a birthing ball and you stayed through all my shouting! Thank you too, to the lovely Alicia H. also who was present for the birth and popped the waters as our boy was born in the sac! She was amazing.

The aftercare we received was great and my wishes to be kept with my birthing partners afterwards due to my Complex post-traumatic stress disorder was completely respected and we were kept in our birthing suite until I was discharged. I was taken care of and discharged by Victoria P who is just lovely and was there whenever I needed anything.

The entire birth was a healing experience I didn’t realise I needed so badly until it happened. Thank you all for supporting, healing and empowering me. We will forever be grateful.

From Kara, Aaron & baby Luca.”

The Journey Continues

The Shrewsbury and Telford Hospital NHS Trust

- We've come a long way.
- We've undertaken a huge amount of work, some transactional, some transformational.
- We're not in a position to say we have delivered and embedded 100% of our actions and are where we want to be. However, the work we have undertaken has established solid foundations that are safe to build on.
- We are really proud of our teams who have all contributed to the improvements, from our obstetricians to our midwives, including our administrative and operational colleagues.
- We are very grateful for the support we have received from colleagues across the Trust, our Executive team, system partners, and external advisors.
- We have yet more to do.

"Always more to do, always more to learn."

Thank You.
Any Questions?