Chief Executive's Report to the Trust Board

Part 1: Feedback from the CQC well-led inspection

Following the Trust's recent well-led inspection, the CQC has written to us with some initial feedback so we can start considering what actions are needed to continue to make improvements in this area of the organisation.

It is important to note that the feedback (shown below) does not replace the draft inspection report. This will be sent to us by the CQC in early March for factual accuracy review.

Leadership

• The Trust had a leadership team that had experienced significant change over the last nine months, with three interim Executive posts, including the Chief Executive. The interim post holders have held Executive posts before and bring experience of how an Executive Team and Board should function. The Executive Team was working as a cohesive group.

• Some Middle Managers lack the skills and knowledge in how to lead and manage effectively. The Trust recognised the training needs of managers and was working to provide leadership and development opportunities, however this was at an early stage.

• The Trust's leadership team had knowledge of current priorities and challenges and was taking action to address these, however there was a history of action and improvements not being sustained.

• Senior leaders made sure they visited all parts of the trust however the staff perception of the visibility of the Board was not positive. There was a lack of systematic fed back to the board from these visits to discuss challenges staff and the services faced.

Vision and Strategy

• The Trust's strategy and vision were developed in 2016 and required review, which the Trust were aware of. Some senior leaders advised that the Values remained current, however strong feelings were expressed by some who felt they were not lived by all staff and also required review.

Culture

• We heard of Executive leaders who had addressed poor practice, but other managers were not consistently taking actions.

• The Trust was not consistently taking action as a result of concerns raised. Some staff felt nothing was done until a grievance was raised.

• Staff, including those with protected characteristics under the Equality Act, do not always feel they were treated equitably. However we did hear about volunteers from different communities who were having positive effects on breaking down barriers.

Governance

• The governance arrangements were becoming clearer, but levels of assurance and confidence in the assurance processes were not mature.

• The Board was clear about its roles and accountabilities, but this was not the case throughout the organisation. Leadership development was not yet in place throughout the different levels of the

organisation and this was apparent in a lack of knowledge and experience in holding difficult conversations, such as at middle management level.

Management of risk, issues and performance

• Risks were not always dealt with appropriately or quickly enough. Systems did not support robust and corroborated information.

• Complaint management lacked detailed learning, nor was there sign off that learning had been achieved.

• There was inconsistent completion of serious incidents investigation forms, with a lack of robust learning from some serious incident investigations. A new process was in place for Executive oversight of serious incidents. We asked the trust to relook at the actions from a specific serious incident as we did not feel these covered all the issues identified.

• The Trust did not have assurance that low and no harm incidents were recorded appropriately and it was difficult to map trends and themes.

• We have asked for up-to-date information on backlog of incidents form as the number had been high and we had conflicting verbal information on if it had reduced and by how much.

• The Trust has had a deteriorating financial performance and has not met its control total in previous years. This trend has continued in this financial year.

• The Trust recognised its challenged financial position and has identified some of the reasons for this performance. Interventions were in place, however no financial improvements were expected in this financial year.

Information management

• There was a heavy reliance on manual systems to provide information with a lack of trust in the data available. This was recognised by the Trust with a digital strategy in development.

Engagement

• A good and diverse range of people's views was heard and acted upon, and we heard of examples of this.

• People with diverse backgrounds were used to engage with staff and promote the understanding of the different needs of people.

• There was a large volunteer workforce who were recruited against the Values of the Trust.

• There were improving relationships with partners, but a need to develop shared vision with supporting actions in order for the Trust to deliver its improvements to patient care.

Learning, continuous improvement and innovation

• Systems lack maturity and senior leaders recognise this. Mortality review process in place but learning to promote safety less clear.

Please see Appendix 1 for full letter from the CQC.

Part 2: Chief Executive's highlight report

3.1 CQC Maternity Survey published

I was pleased to read the findings of the 2019 CQC Maternity Survey (*published on 28 January 2020*) which showed that women cared for by SaTH had confidence and trust in the staff caring for them during their labour and the birth of their baby.

The CQC survey highlights women's views on all aspects of their maternity care from the first time they see a clinician or midwife, through to the care provided at home in the weeks following the arrival of their baby.

With that in mind, it is pleasing that the Trust scored 8/10 or higher in 73% of the questions asked. Of the 35 questions in which SaTH achieved this scored, 21 (60%) scored 9/10 or higher.

Findings of the survey include:

- Women having confidence and trust in the staff caring for them during labour and birth.
- Women being treated with dignity and respect.
- Concerns being taken seriously.
- Midwives listening to women during their antenatal check-ups.
- Women getting the help they needed, when they needed it.
- Women being spoken to in a way they could understand.
- Women being involved in decisions about their care.

3.2 Two new wards opening soon

Two new wards are being created to increase capacity at PRH and RSH.

A 25-bed therapy-led ward/discharge lounge will open at RSH over the coming weeks, while a 16-bed ward will open at PRH.

The therapy-led ward/discharge lounge will open in the Copthorne Building at RSH and has been designed to shorten the length of stay for patients, while freeing up acute beds.

The new ward at PRH will be created as a result of Wrekin MLU moving into a purpose-built modular building next to the Consultant-led Unit.

The building, which will house a new state-of-the-art MLU at PRH, was lifted into place over Christmas and will include a birthing pool and en-suite bathrooms. It has been designed with the leadership team from the Women and Children's Care Group.

3.3 Equality, Diversity and Inclusivity improvements

We held our second annual Equality, Diversity and Inclusivity Stakeholder event on Thursday 23 January, where staff from across SaTH presented information about a range of services.

Each 10-minute presentation was followed by group discussions on what the service is doing well and what improvements could be made to meet the needs of the local community.

In February, We will be holding two LGBT+ awareness workshops to support LGBT+ History Month. The Trust also recently introduced the Rainbow Badge scheme, in which staff can apply for a badge to champion and demonstrate awareness of the issues that lesbian, gay, bisexual, transgender (LGBT+) people can face when accessing healthcare.

In March, Kal Parkash will join us to take up a brand new role - Equality, Diversity & Inclusion Lead. She joins the Trust from West Mercia Police where she was shortlisted for the National Excellence in Diversity Awards, in recognition of increasing BME representation.

3.4 Two more Exemplar Wards

The Delivery Suite at the Princess Royal Hospital (PRH) in Telford has been awarded Diamond status as part of the organisation's Exemplar improvement programme.

The Delivery Suite becomes the fourth department at SaTH to be crowned with a diamond, while the Children's Ward recently achieved Gold status.

Patient experience is at the heart of Exemplar – which awards Silver, Gold and Diamond to participating wards. Wards must show strong leadership to inspire their entire team to make changes in areas including care and compassion, infection control, documentation and communication in order to improve a patient's journey through their ward.

3.5 Improving Care of patients presenting with mental health conditions

Using our Transforming Care Production System methodology we have been exploring ways to improve the care of patients presenting with mental health conditions in our Emergency Departments (EDs).

During the week-long event, where staff were joined by Lynda Jones, an independent mental health activist, a number of new process were designed and are now being trialled in our EDs.

Improvements made during the week include:

- A Mental Health Triage Tool is to be introduced alongside the Physical Health Tool that is currently used in our EDs. The tool will be used to decide the next course of action for the patient.
- A step-by-step guide has been created to ensure all staff are fully aware of the correct pathway for 16 and 17-year-olds presenting in ED with a mental health condition.

- Information folders are to be created containing important information, including the flowchart and the Mental Health Triage Tool, and contact details of external organisations that may be able to assist in the delivery of great patient care of those presenting with a mental health condition.

3.6 Recognition and treatment of Sepsis

We welcomed Dr Ron Daniels, CEO of the UK Sepsis Trust, to both PRH and RSH on Tuesday 28 January. Ron delivered a fascinating lecture on the changing face of Sepsis and held a Q&A session at both sites, providing staff with the opportunity to make suggestions, raise concerns and have open and robust discussions about the condition.

We have been working hard to understand the wider issues contributing to our current position and, as well as the visit of Dr Daniels, we have made a number of significant improvements in recent months.

These include the introduction of more Sepsis Trolleys, updating the staff app so staff can locate clinical information quickly and increased education.

3.7 Successful flu campaign

Our #WeWillRockFlu campaign has been a huge success with over 80% - the national target - of frontline staff at the Trust having their jab.

The Trust has less than 200 vaccinations left and anyone who has not yet had the jab is urged to organise it by calling our Flu Line on Ext 2525.

Our IPC, Workforce and Communications team have worked closely together to make this our most successful Flu campaign ever.

3.8 Indian Nurses welcomed to SaTH

You will recall that in October the Trust has announced that it has recruited 176 nurses from India. I am pleased to report that the first cohort arrived in December and the second cohort in January.

This is extremely good news for our patients and our staff, and I am delighted to hear that our new nurses are settling in well to life at SaTH.

Their arrival in cohorts means we can ensure that the standards of proficiency, education and training meet our high standards.

The Trust has looked to overseas recruitment, through Health Education England's (HEE) Global Learners programme, to help fill gaps in its substantive nursing and midwifery workforce. The HEE programme was implemented to meet the shortfall of over 270 band five nursing and midwifery vacancies in the trust and these appointments will help to improve the care we give to our patients.

3.9 New CT Scanner now live

We now have four CT scanners in operation following the introduction of a new state of-the-art CT scanner at PRH before Christmas.

The additional scanner will ensure the sustainable and reliable delivery of emergency and urgent CT scanning, particularly for stroke and paediatric patients. Its superior technology will also allow for improved image quality and advanced imaging, such as cardiac.

Alongside the scanner is a newly-created three-bedded bay which will be used for patients waiting for a CT scan, allowing them more privacy.

The scanner and bed bay are part of a £7 million investment in our Radiology department which aims to improve patient care and experience. It means that should one of the scanners need essential maintenance or be out of use, patients will no longer have to be transferred to RSH for their scan.

3.10 Careers event

We are hosting a careers event in partnership with Shrewsbury Colleges Group on Wednesday 12 February, from 4pm—7pm at the Shropshire Conference Centre (SECC).

This is a chance to meet NHS Staff working across our hospitals, find out about their roles, have a tour of hospital facilities, and discuss relevant courses with Shrewsbury College staff. There will also be guidance on apprenticeships within the Trust and how to apply for a role.

As well as stands and hands-on activities, there will be talks every 30mins: the NHS will showcase the routes into their diverse job roles including work experience and apprenticeships, and SCG will highlight the many qualifications and course packages we can offer for these careers.

3.11 Louise Barnett to start in February

Louise Barnett will join SaTH as Chief Executive in February.

Louise is currently the Chief Executive at The Rotherham NHS Foundation Trust, having joined them as interim Chief Executive in October 2013, prior to being appointed to the substantive position in April 2014.

She has previously held a number of NHS board positions, including Interim Chief Executive, and Director of Human Resources and Organisational Development at Peterborough and Stamford Hospitals NHS Foundation Trust and Non-Executive Director at Sherwood Forest Hospitals NHS Foundation Trust.

Part 3: Senior Leadership Team (SLT)

The Senior Leadership Team met on 28 January 2020. The following provides a summary of the key items which were discussed:

- **Dr Ron Daniels, CEO of UK Sepsis Trust**, started his day at SaTH with the Senior Leadership Team (SLT) meeting, where he talked about the Red Flag system to aid clinical decision making, and that the UK Sepsis Trust accepts a variance from clinical pathways as long as the reason for variance is documented. He acknowledged that this needs to be communicated to staff at all Trusts. Following the SLT Ron went on to deliver a lecture on the changing face of Sepsis and held a Q&A session at both sites, providing staff with the opportunity to make suggestions, raise concerns and have open and robust discussions about the condition.

- Our Chief Operation Officer and his team talked about how they are **trying to feed expected winter demand for next year**, now, to NHSI to improve our demand capacity modelling and to have planning discussions much earlier.

- **Key updates** from Unscheduled Care, Scheduled Care, Women and Children's and Clinical Support Services were shared and discussed.

Part 4: NHSI/E weekly bulletin updates

Each week we receive a bulletin from our regulators at NHSI/E which provides us with an overview of national policy developments, key events and details of actions that we are required to take forward. Some key highlights from January include:

- It is the **International Year of the Nurse and Midwife**. This is the year we recognise and celebrate the enormous contribution that nurses and midwives make to all of us, our health services and our patients. It is our chance to shine a light on the skills and expertise it takes to be a nurse or midwife, and to encourage new recruits into the professions.
- A change in the law means **two new groups have a legal right to a personal health budget**. This includes people eligible for after-care services under Section 117 of the Mental Health Act and people eligible for an NHS wheelchair (who have a right to a personal wheelchair budget). This guidance is available to support clinical commissioning groups and other bodies to meet their duties in line with the new rights.
- The **National Medical Examiner team** is beginning reimbursement of approved costs for 2019/20. If your trust is recruiting for or running a medical examiner system in 2019/20 and you have not yet received the initial data collection template, please contact funding.nme@nhs.net urgently.
- We are inviting expressions of interest in **NHS stroke rehabilitation pilot sites**. Further to the NHS Long Term Plan commitment, the sites will implement and evaluate evidence for stroke rehabilitation services and inform future national stroke service developments, to help people recover after their stroke and remain as independent as possible.
- We have launched a **consultation on the suitability of the dementia assessment and referral** (DAR) data return used by acute trusts, and whether it should remain open or be closed.
- The **'Pharmacy Advice' phase of the Help Us, Help You winter campaign** launched this week. Pharmacists can treat minor concerns like coughs, colds, sore throats, itchy eyes and earaches, helping to reduce pressure on busy GPs and A&Es. The campaign asks the public to 'take the drama out of minor illnesses' and go to their local pharmacist first. It includes a TV advert, social media and bus shelter adverts to help change behaviour.
- Advice on **Wuhan coronavirus**. The latest information and guidance on the Wuhan novel coronavirus is available from Public Health England.

Part 5: Maternity update

Background:

In 2017 the Secretary of State for Health asked NHS Improvement to commission a review of 23 cases where babies and mothers had died or potentially suffered significant harm whilst receiving care at the Trust. Donna Ockenden, expert in midwifery and maternity care, was appointed as chair to gather a clinical team. Donna produced an internal status update report at the end of January 2019. The Trust became aware of the status report in November 2019 when it was leaked to the media and it was then discussed at the November Trust Public Board meeting. Whilst the report was interim the Trust board felt it was important to address the key themes as part of the ambition to achieve best practice standards of care and the Interim Chief Executive undertook to return with an update at the 6th February 2020 Board meeting.

Status Report and Emerging Themes for Learning:

Since the review was launched and subsequent media coverage, the number of cases has risen and stands at over 900 as at January 2020. It was therefore imperative that the emerging themes were mapped against actions taking place within the Trust currently to establish any gaps and then to address these at pace for the families who have suffered loss and the confidence of the wider population.

There are 10 key emerging themes with some overlap, so where this is the case the Trust actions and response have been grouped into the seven areas below.

1) **Theme for Action:** All women should be able to make a fully informed choice and consent around maternity care and choice of place of birth in particular based on their own unique risk profile.

   Response:

   We recognise that further improvements are needed in this area. Conversations about choice and relative risks take place with women throughout their care but these are not always fully documented. The decision about choice is guided by the professionals based on the risk profile of the woman. Although women can access additional information themselves we still believe we could be better at directing and explaining. (https://www.nhs.uk/conditions/pregnancy-and-baby/where-can-i-give-birth/).

   An information leaflet is being developed with the maternity team and this will be in place by end of March 2020 using best practice from other Trusts and the link above.

   "Place of Birth" Guidelines underway to be completed March 2020 in line with national guidance.

2) **Theme for Action:** Duty of candour and transparency/Categorisation of Serious Incidents must be appropriate and to be evidenced. Openness and transparency through involvement of families from the outset in Serious Incident reviews including acknowledgement or explanation of the factors that have led to the death of a baby or to a poorly handled birth leading to long term consequences for the mother / and baby.

   Response:

A huge amount of work has been done in this area in response to the Royal College of Obstetricians and Gynaecologists (RCOG) report and improvements in the Duty of Candour adherence throughout the Trust.

A Clinical Incident Management Policy has been in place since 2018 which has been reviewed and checked. Families are also informed by letter around the process being undertaken. Healthcare Safety Investigation Branch (HSIB) is in contact with families as part of a review of incidents meeting Each Baby Counts criteria.

Being Open and a Duty of Candour Policy is in place. There is clear process for Duty of Candour in the Care Group and reviews are undertaken to ensure compliance and a review in line with psychological harm.

All datix incident reports are now seen by the Executive team and ESIRG (Executive Serious Incident Review Group) has been running since November on a weekly basis at which all SIs are reviewed and checks on duty of candour and patient/family involvement made.

A monthly maternity agenda item will now be tabled at every public Board from February 2020.

3) **Theme for Action:**

Kindness and respect for parents and families.

Response:

There is recognition that in the past kindness and empathy were lacking for some patients, particularly when families and mothers needed this to be central to their care in difficult and sad circumstances.

The entire Trust is undergoing a Culture Survey to better understand the culture within the organisation as a whole which underpins the way staff interact with and care for patients and families. The recent Staff Survey has shown some improvement, the results of which are being used to roll out organisational development actions.

The recent CQC review of maternity and the forthcoming survey of new mothers evidenced a positive culture of kindness and care as did their recently published maternity survey.

In addition to our informal avenues for feedback and the Friends and Family test (which is showing 100% recommendation of service to others), a formal “contact us” card is being produced so that every new Mother can come back to us with their views as they leave our service. We are actively engaging with women to get feedback.

4) **Theme for Action:** Respect accorded to the deceased baby and lack of kindness to the families. Time must be allowed for families to be with their baby and that viewing facilities are to a high standard and appropriate to the situation.

Response:

The Trust recognises that the facilities for families for viewing and spending time with their deceased baby was inadequate.

Since the CQC visit in October work has been underway to improve the facilities for families who suffer the loss of a baby or child. Mortuary staff have been involved in this work along with the Care Group team, Chaplain and Estates.

Full review of Bereavement Services is planned involving SANDS (Stillbirth and Neonatal Death Society) with SANDS training also to be undertaken within Trust.

Implementation of National Bereavement Care Pathway.

5) **Theme for Action:** Providing maternity bereavement support and a structured system of support for families who have suffered loss or harm.

Response:

As Theme 4) Full review of Bereavement Services within the Care Group involving SANDS Implementation of NBCP and Maternity Experience Bereavement measure to gain feedback from women.

A business case has been signed off for a SANDS support proposal.

A business case has been approved for second Bereavement Midwife.

6) **Theme for Action:** Essence of learning "missing" – incident, governance, investigation processes and Root Cause Analysis reports brief and fail to identify key issues.

Response:

We recognise learning and the embedding of changed practice is a work in progress for the whole Trust and is not consistently applied. This was flagged at the recent CQC inspection. As part of their ongoing surveillance we are working with them to demonstrate improvements which will be tested when they return later in the year.

Maternity services are more mature in this area. In the maternity service focus has been given to RCA management, learning from incidents and applying this consistently.

Maternity team take part in multi-disciplinary training (over 90%) compliance with particular focus on managing emergency situations.

A full Trust wide governance review has taken place in the Care Groups generally to ensure that the appropriate governance processes are in place. Recommendations have been made to ensure consistency and appropriate escalation to higher tier Board Committees and the Board. In the Women and Children's Care Group this is well advanced.

Governance structures at Board level have also been reviewed and changes being implemented.

7) **Theme for Action:** Maternity services and links go into the "wider NHS world" for bringing in best practice learning. Implications of RCOG, MBRRACE etc and other external and internal reviews are adopted and monitored to ensure learning and embedded improvements in practice.

Response:

Since 2017 the team in Maternity Services have taken a proactive approach to looking outwards and bringing in new staff from other NHS Trusts with their own experience.

We have new senior appointments in place including our Director of Midwifery, who has recently joined from another Trust, having led them from Inadequate to Good. Our management leadership team has also been strengthened and we are currently seeking a new Clinical Director for the Obstetric and Gynaecology Service.

Our Director of Midwifery is the Vice Chair for the West Midlands Heads of Midwifery Advisory Group which has membership for heads of midwifery for the whole region.

In terms of the medical team they routinely take study leave outside the Trust nationally and internationally and learning forms an important part of their appraisal and revalidation.

Implementation and monitoring of national recommendations via appropriate governance channels also takes place.

We have a newly implemented process whereby all external review reports are taken to the Executive team meetings and then onto Board, each month as they arrive.

MIST e-learning programme

SaTH, in partnership with Health Education England and The Newcastle upon Tyne Hospitals NHS Foundation Trust, has developed the MIST e-learning programme to support maternity and emergency teams treating unexpectedly unwell newborn babies in community settings.

MIST (Midwifery Identification, Stabilisation and Transfer of the Sick Newborn) is aimed at midwifery and ambulance colleagues to support the treatment plan for newborn babies who are, or have the potential to become, unwell following delivery in a community setting.