Forward ORAC Plan

The Shrewsbury and Telford Hospital NHS Trust

Date	Agenda Structure	LAFL/ IEA Reference	Theme	Presenter
Jan-23	1. High-level Ockenden plan update (first report) 2. High-level Ockenden plan update (final report) 3. Thematic engagement piece/measurable benefits	Narrative from first report	Compassion and kindness	• Annemarie Lawrence – Director of Midwifery • Carol McInnes – Director of Operations, W&C
Feb-23		First Report: IEA 2 Final Report: LAFL 14.10-12	• Listening to women and families (MVP and safety champs) • Communications plan update	TBC
Mar-23		First Report: IEA 1 and IEA 3 Final Report: IEA 5 & LAFL 14.15-17	Learning from complaints and investigation	TBC
Apr-23		First Report: LAFLs 4.85-91 Final report: IEA 11 & LAFL 14.51-55	Integrated working - Obstetric Anaesthesia	TBC
May-23		First Report: IEA 7 Final Report: IEA 12 & LAFL 14.60-61	Postnatal support	TBC
Jun-23		First report: IEA 7 Final report: IEA 10	Informed birth choices	TBC
Jul-23		First report: LAFLs 4.97-100 Final report: IEA 11 & LAFL 14.56-59	Safe and effective care – Neonatal care	TBC

To be included: MBRRACE Data

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Ockenden Action Plan Update (First Report)

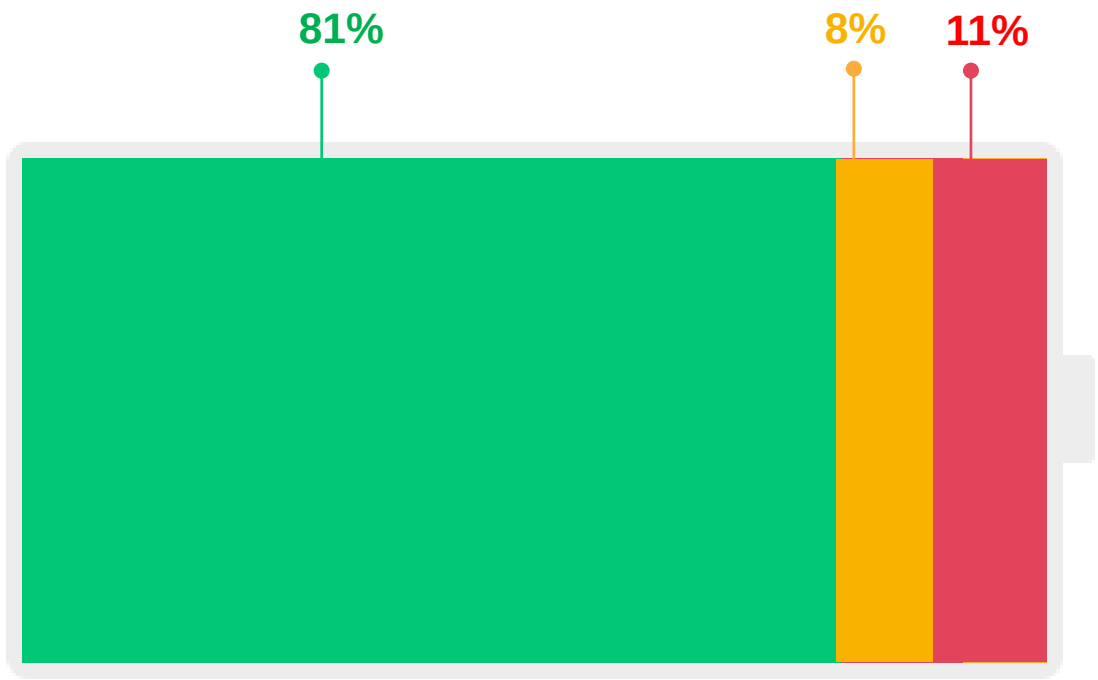
Date: 31.01.2023

Presenter:

- Mei-See Hon, Clinical Director for Obstetrics, W&C Division

Ockenden Action Plan (First Report) – Completion Rates

First Report - Completion Battery



46/52 Actions Implemented (88.46% overall), comprising:

- 42 (81%) ‘Evidenced & Assured’
- 4 (8%) ‘Delivered, Not Yet Evidenced’

6 (11%) Actions ‘Not Yet Delivered’. Of these, 3 are ‘Off Track’ and 3 ‘On Track’

‘Not Yet Delivered’ – Red Actions

The Shrewsbury and Telford Hospital NHS Trust

ID	Dependent	Reasons	Deadline	Progress
LAFL 4.88	Internal	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. Guideline update underway.	Jun-23	On Track
LAFL 4.100	Internal	Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit. Plans underway for ANNPs to attend another NICU.	Oct-23	On Track
IEA 1.4	External	The action states that ‘an LMNS cannot function as one maternity service only’. LMNS colleagues are working on buddying-up agreement, in partnership with SaTH and potential partner LMNS’s.	Jun-23	On Track
IEA 2.1	External	This action relates to Trusts creating an independent senior advocate role which reports to both the Trust and the LMNS Boards. These roles are being developed, defined and recruited nationally. It is understood that this process in underway. Action to remain ‘off track’ with due date of ‘TBC’ until timeframes are known.	TBC	Off Track
IEA 2.2	External	The action states that the advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Once in post, methodology for this is to be developed. Action linked to 2.1.	TBC	Off Track
IEA 2.4	External	This action indicates that 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 (MVP). The rests with the CQC to deliver. Action to remain ‘off track’ with due date of ‘TBC’ until timeframes are known.	TBC	Off Track

Summary (First Report)

Summary (First Report)

The Shrewsbury and Telford Hospital NHS Trust

- 46/52 actions ‘Delivered’. We are carrying out audits to ensure that the actions remain green and are refreshing the evidence to keep it up to date.
- 6 actions ‘Not Yet Delivered’, 4 lying outside of SaTH’s direct control (external dependency linked to LMNS, CQC and NHSEI):

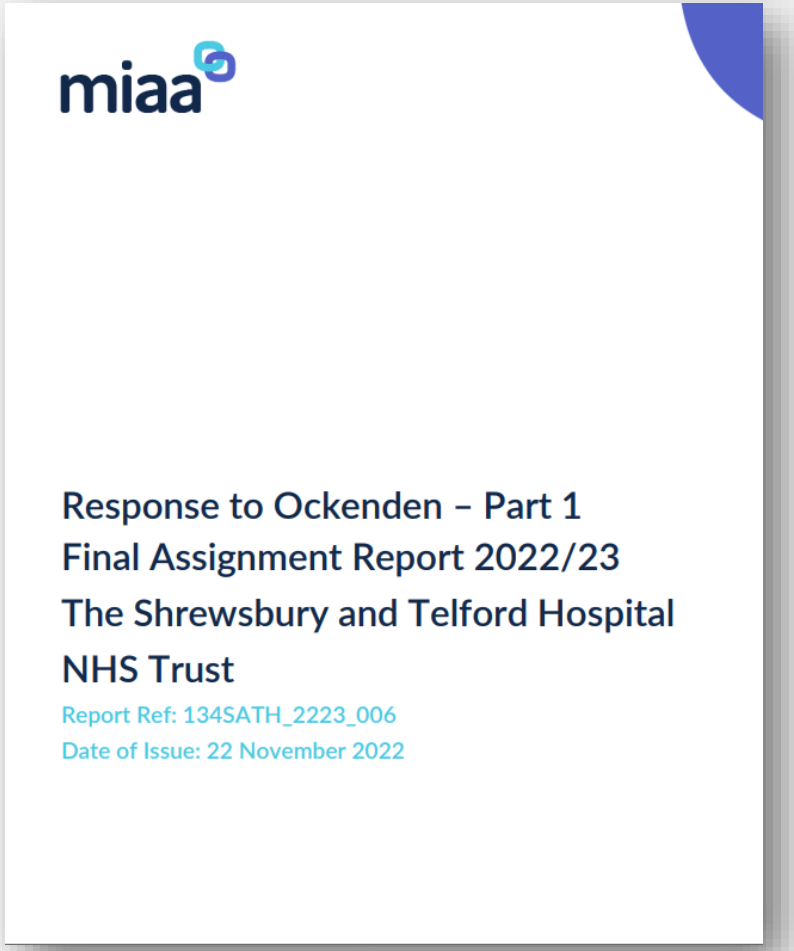
    - We have been informed by our system stakeholders that work is underway on all of them.

    - IEA 2.1, 2.2 and 2.4 set as ‘Off Track’ until clear timeframes can be provided. Work is underway with system stakeholders to try and resolve these.

Mersey Internal Audit Agency (MIAA) Audit Results –

Review of compliance with the 7 IEAs from the First Report

MIAA Audit – Substantial Assurance



- The overall objective was to review the processes the Trust has in place to monitor and report on the implementation of the Immediate and Essential Actions raised in the Ockenden Report (Part 1). Audit findings presented at audit committee on 30.11.2022.
- The report identifies many positive aspects relating to the governance and assurance of the Ockenden actions, including use of reverse RAG, Agile project management methodology, stakeholder involvement and the assurance journey from the service to Board.

Recommendations:

1. 'We encourage the Trust to maintain their focus and momentum at prioritised pace to fully address the remaining Ockenden actions to Green RAG rating. (Medium Risk)'.
2. 'A (Low Risk) rated recommendation is made for completeness in that it would be of benefit to include copies of the relevant AAA reports on the Monday.com files where these are referenced and form part of the overall evidence and assurance for Ockenden actions.'

Thank You. Any Questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Ockenden Action Plan Update (Final Report)

Date: 31.01.23

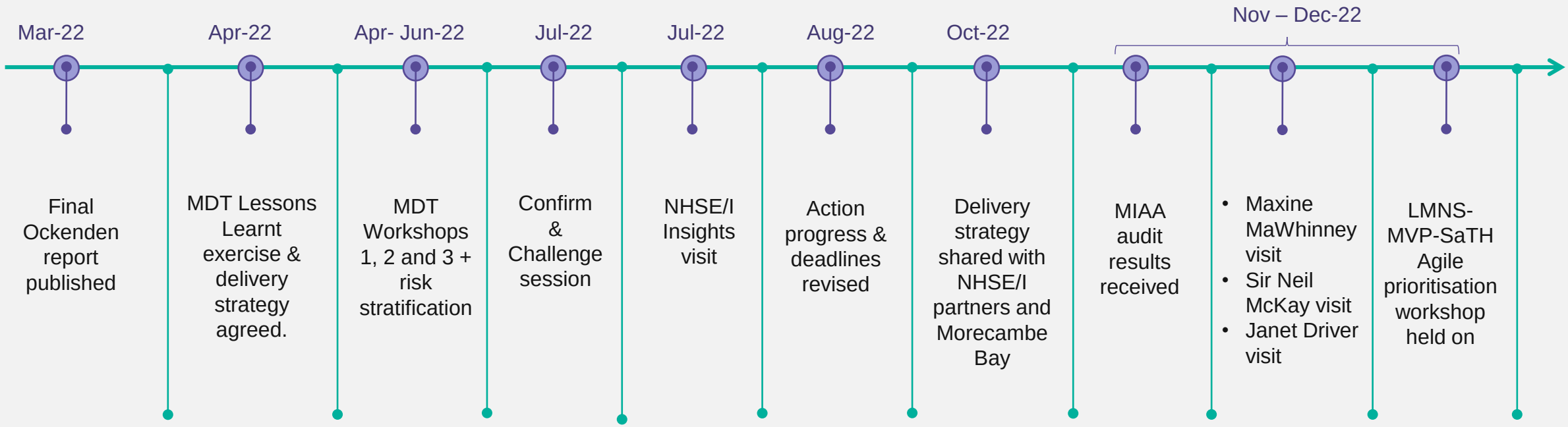
Presenter:

- Annemarie Lawrence, Director of Midwifery

Timeline of Events

High-level Timeline of Events

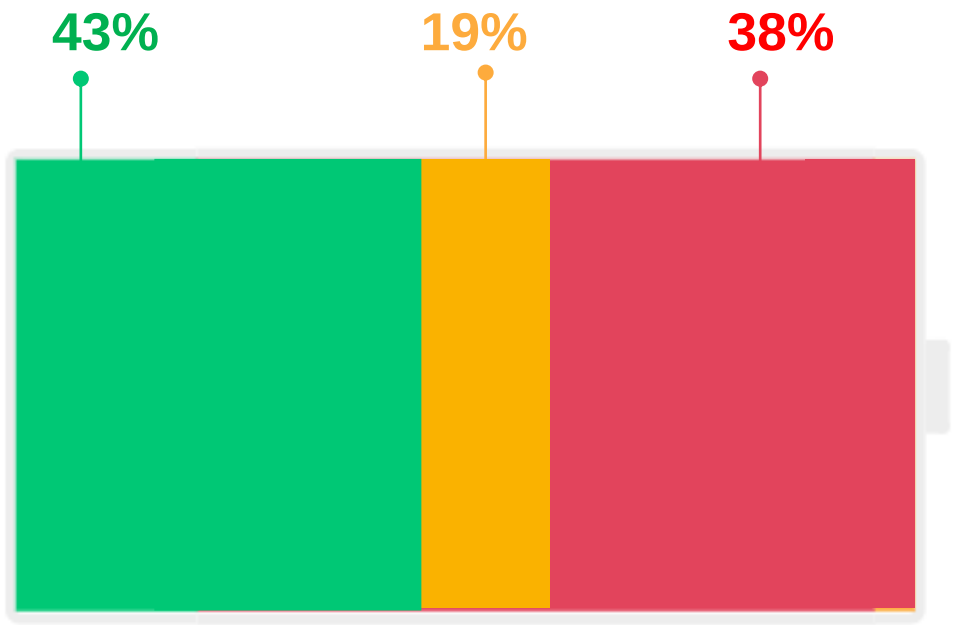
The Shrewsbury and Telford Hospital NHS Trust



MTAC	Acknowledgements	18	1	17	5	29	9	33	10	36	14	50	22	55	31	63	30	68
	Apr-22 MTAC	May-22 MTAC	Jun-22 MTAC		Jul-22 MTAC		Aug-22 MTAC		Sep-22 MTAC		Oct-22 MTAC		Nov-22 MTAC		Dec-22 MTAC		Jan-23 MTAC	

Ockenden Action Plan (Final Report) – Completion Rates

Final Report – Completion Battery



- 68 actions (43%) green – ‘Evidenced and Assured’
- 30 actions (19%) amber – ‘Delivered, Not Yet Evidenced’

62% implemented (98/158 actions) as of Jan-23 MTAC.

From the 60 actions (38%) ‘Not yet Delivered’, 46 actions (29%) are ‘On Track’ for progress

Actions approved at Nov-22 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Ockenden action	Theme	Description	Status change approved
IEA 1.2	Workforce planning	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.	
IEA 6.3	Learning from maternal death	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. 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 LMNS.	
IEA 8.3	Complex antenatal care	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	

Actions approved at Nov-22 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Ockenden action	Theme	Description	Status change approved
IEA 5.6	Incidents and investigations	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent	
IEA 9.2	Preterm birth	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	
IEA 11.8	Obstetric anaesthesia	Obstetric anaesthesia staffing guidance to include: Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	
LAFL 14.6	Improving incident management	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.	
LAFL 14.15	Improving complaints handling	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	

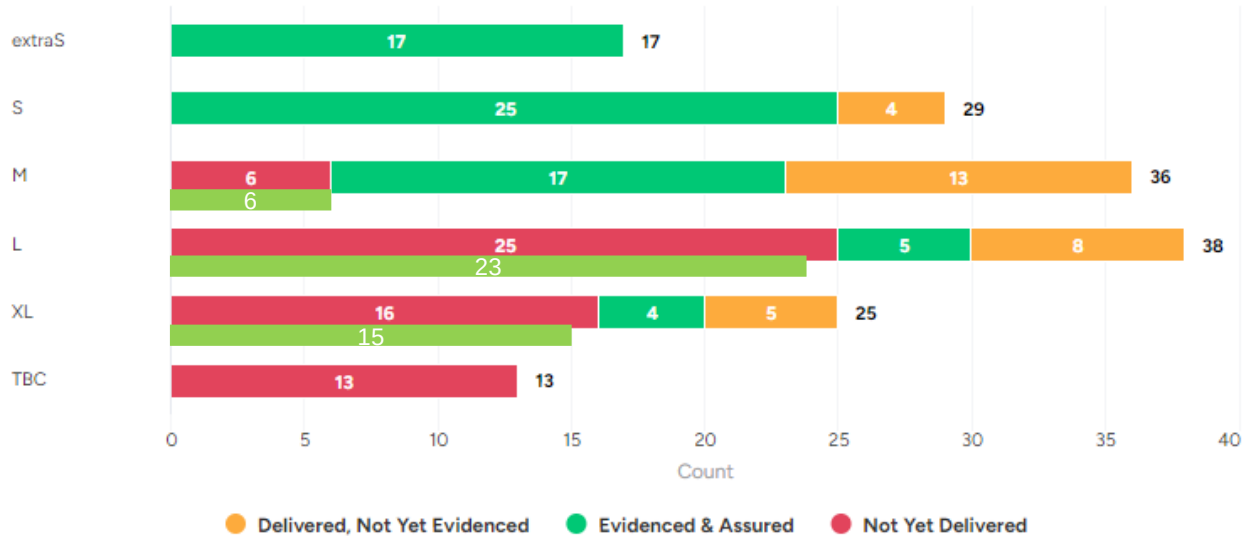
Summary (Final Report)

Summary (Final Report)

The Shrewsbury and Telford Hospital NHS Trust

- From the final report, 98/158 have now been ‘delivered’ (62%). From the 38% ‘not yet delivered’, over two thirds of these are underway.
- There is still much more to do.
- Work continues at pace to deliver the rest of the programme.

Size	Amber date	Green date
XS	**May-22**	**Jun-22**
S	**Sep-22**	**Jan-23**
M	**Dec-22**	Apr-23
L	May-23	Aug-23
XL	Nov-23	Mar-24



Thank You. Any Questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Compassion and Kindness

Date: 31.01.23

Presenters:

Carol McInnes, Director of Operations

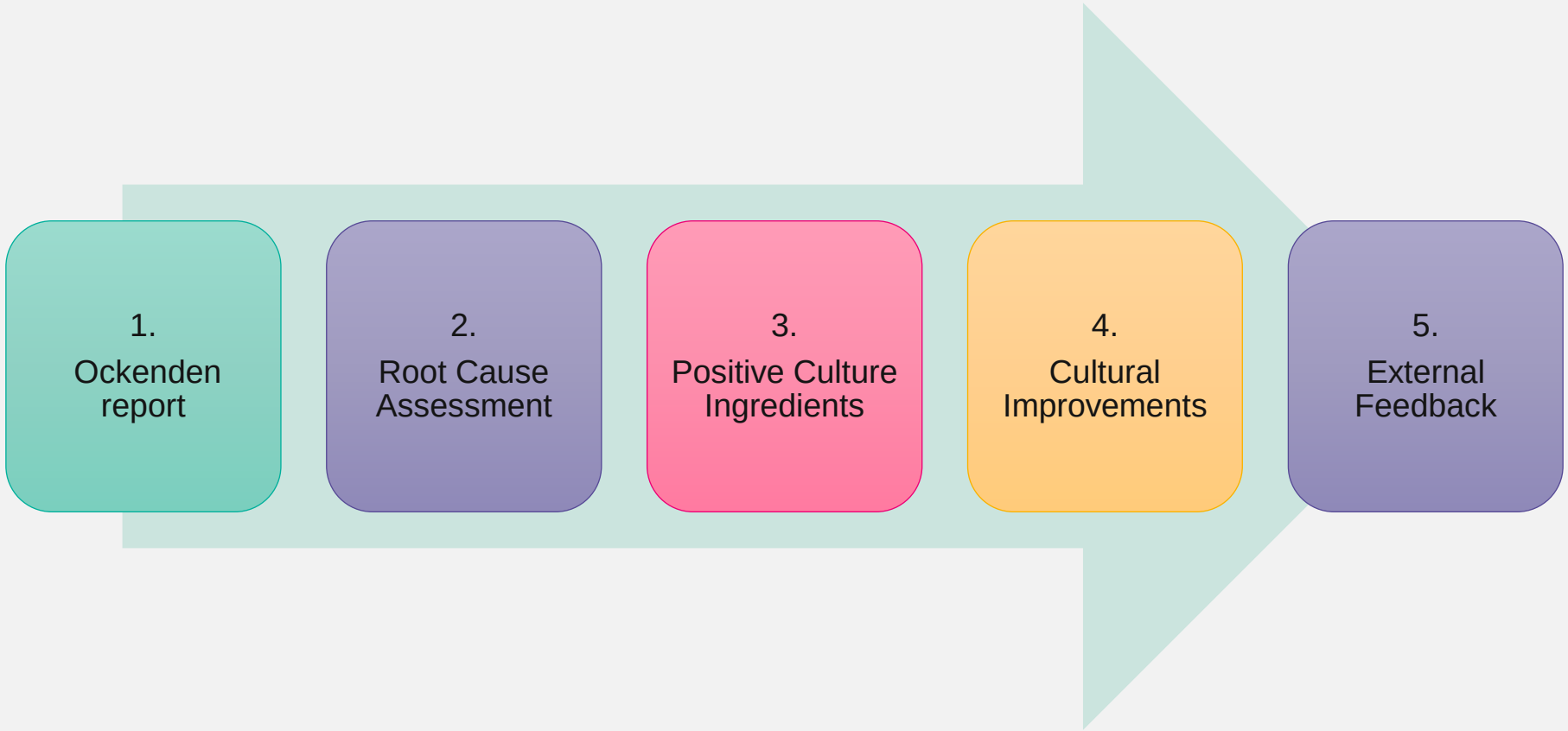
Annemarie Lawrence, Director of Midwifery

Workstream Structure

The Shrewsbury and Telford Hospital NHS Trust

1. Clinical Quality & Choice	2. People & Culture	3. Governance & Risk	4. Learning, Partnerships & Research	5. Comms & Engagement	6. Maternity Improvement Plan	7. Anaesthetics
						
Guy Calcott Obstetrics Consultant **Mei-See Hon** Clinical Director – Obstetrics	**Rhia Boyode** Executive Director of People and OD	**Claire Eagleton** Deputy Director of Midwifery	**Fiona McCarron** Consultant Midwife	**Kim Williams** Deputy Director of Midwifery	**Annemarie Lawrence** Director of Midwifery	**Lorien Branfield** Consultant Anaesthetist

Presentation Structure



Three videos of staff testimonials incorporated into presentation

Ockenden Reports

Presenter: Carol McInnes

First Ockenden Report - Compassion and Kindness

The Shrewsbury and Telford Hospital NHS Trust

‘One of the most disappointing and deeply worrying themes that has emerged is the reported lack of kindness and compassion from some members of the maternity team at the Trust. Healthcare professionals are in a privileged position caring for women and their families at a pivotal time in their lives. Many of the cases reviewed have tragic outcomes where kindness and compassion is even more essential. The fact that this has found to be lacking on many occasions is unacceptable and deeply concerning.’

‘… Inappropriate language had been used at times causing distress. There have been cases where women were blamed for their loss and this further compounded their grief. There have also been cases where women and their families raised concerns about their care and were dismissed or not listened to at all.’

‘A woman was in agony but told that it was ‘nothing’; staff were dismissive and made her feel ‘pathetic’. This was further compounded by the obstetrician using flippant and abrupt language and calling her ‘lazy’ at one point. (2011)’

Source: Ockenden report: Independent Maternity Review, 2020

Root Cause Assessment

Presenter: Carol McInnes

Root Cause Assessment

Ingredients for a Better Culture

Presenter: Carol McInnes

Ingredients for a Positive Culture

Testimonial 1/3

Note: All colleagues provided consent to be filmed and for these to be used at this meeting


hello my name is
Helena
Specialist Midwife

Work Underway

Presenter: Carol McInnes

Work Underway

Testimonial 2/3

Note: All colleagues provided consent to be filmed and for these to be used at this meeting


hello my name is...
The Shrewsbury and Telford Hospital NHS Trust
NHS
Tasha
Slater

Externally-conducted Cultural Review

The Shrewsbury and Telford Hospital NHS Trust

- Implementing long-lasting cultural change is at the core of the work undertaken in the People & Culture workstream of the Maternity Transformation Programme. The division is committed to improving the culture of it's services, which will foster a better work environment for our staff and lead to better care for our service user.
- Multiple pieces of work have been underway since the beginning of the Maternity Transformation Programme, not all under it's overview. To help us link all of those initiatives together into a more cohesive plan, we secured the services of an external consultant who will also support in it's delivery.

Phase 1 ✓

- Gain insight about the culture of the Service
- Understand the direction the service wants to move towards and what is needed for success
- Recommend a way forward

Phase 2

- Gather information about initiatives already in place and any ongoing work
- Identify gaps
- Create plan

Phase 3

- Implementation

Strengthened Systems and Processes

The Shrewsbury and Telford Hospital NHS Trust

We have a new Senior Leadership Team.

All processes have been reviewed:

- All teams have clear lines of accountability
- All team leads are clear on roles and responsibilities
- All processes have been formally standardised and communicated
- All teams now compliant with policies (e.g., to avoid nepotism)
- Mechanisms in place accessible to all tiers of staff for rapid and consistent communication sharing
- Additional investment secured (e.g., project management team)

Improving Morale - Communications

The Shrewsbury and Telford Hospital NHS Trust

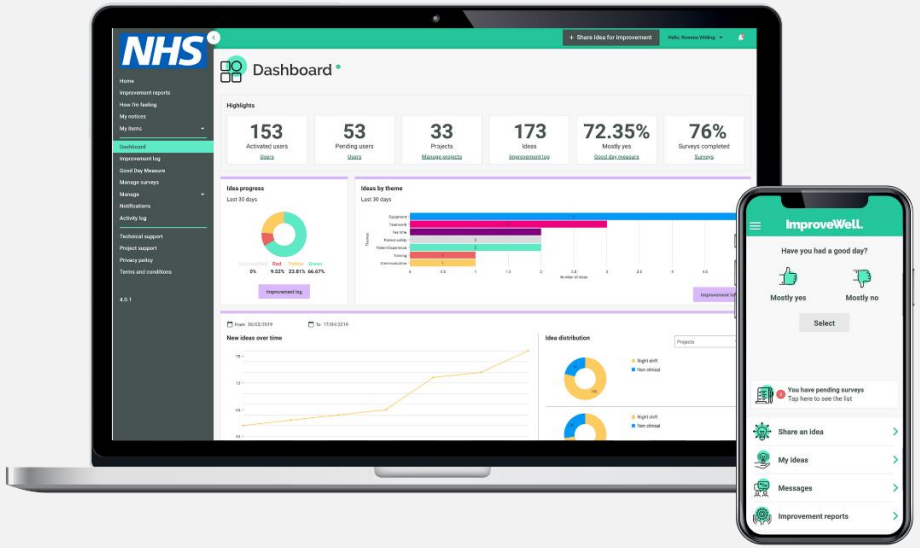
- Website
- Social media
- Press
- Other Engagement Initiatives (e.g., ORAC)

Improving Staff Morale

The Shrewsbury and Telford Hospital NHS Trust

- In February 2022, an app called Improvewell was rolled out to maternity staff. The platform gives all staff a voice, and solution helps our organisation improve staff experiences and patient quality care from the ground up.

- The app offers **4 main features:**
  - Sentiment tracker (have you had a good day?)
  - Idea hub
  - Pulse surveys
  - Push notifications.



Improvewell Outputs

The Shrewsbury and Telford Hospital NHS Trust

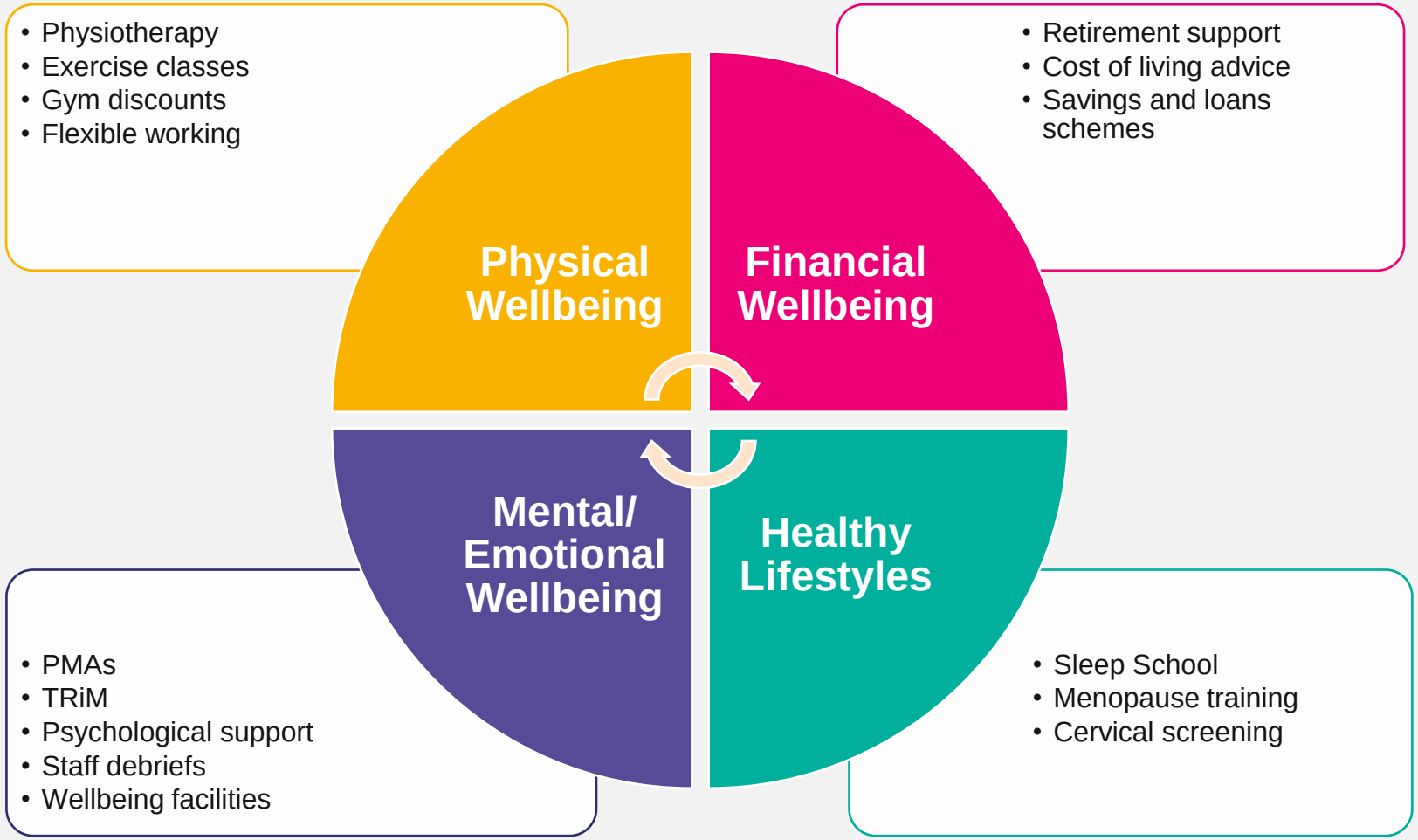
Sep - Dec-22

Ideas generated:

- ✓ Translator Services
- ✓ Easier Login
- ✓ Light projectors in Delivery Rooms
- ✓ New privacy curtains
- ✓ New Keyboards

Staff Health and Wellbeing Offer

The Shrewsbury and Telford Hospital NHS Trust

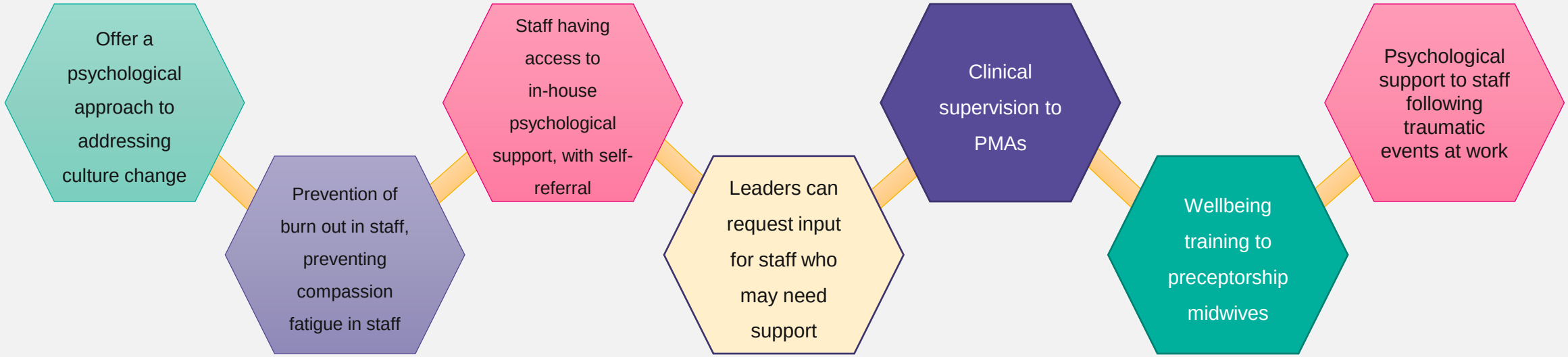


Staff Support - Psychologist

The Shrewsbury and Telford Hospital NHS Trust

- Team of Clinical Psychologists recruited to work with staff across the Trust.
- Lead Psychologist in post since September 2022. 4 additional Psychologists recruited and are due to start in February 2023.

Impact:



Developing a Learning Culture

Review of all processes to strengthen learning via:

- Staff huddles (Governance team included)
- 3-minute brief
- Complaints folders on wards

Underpinned by:

- ‘Human Factors’ training
- ‘Just Culture’ processes
- ‘Civility Saves Lives’ training

Testimonial 3/3

Note: All colleagues provided consent to be filmed and for these to be used at this meeting

Patient feedback

Presenter: Carol McInnes

Patient feedback

“I don’t know if you recall but I contacted you regarding post natal support after having 2 bad experiences with the trust with my first 2 children and was anxious about my pregnancy.

I just wanted to let you that I managed to see Julie and Helen before I gave birth and Helen was able to come out and see me and my son on day 1 and Julie continued my care until I was discharged. Both midwives are an absolute credit to the trust and I can’t thank them enough especially Julie who I have seen regularly. They are knowledgeable, have a wealth of experience, are caring and compassionate and always have your best interests at heart. They took my concerns from my past poor post natal experiences and also my previous experiences as a mum on board and it has meant I have and am thoroughly enjoying the new baby experience with my son and as a result have struggled less with breast feeding and anxiety. I wish they were my midwives when I had my first 2!

I hope and think they know how grateful I am to them but felt it was important that you knew too”.

Conclusion

Presenter: Carol McInnes

Conclusion

- We must continue focusing on delivering excellent care to women and families
- We have made lots of improvements. However, there is still lots to do
- We must continue to embed the learnings and sustain the improvements
- We must improve the way we celebrate our successes
- Our aim is to increase the confidence in our services amongst the communities we serve

Additional Information for ORAC

Presenter: Annemarie Lawrence

Relationship with MVP

- Attendance at monthly maternity governance
- Attendance at monthly Maternity and Neonatal Safety Champions meeting
- 1:1 with Director of Midwifery – project updates and feedback shared for learning
- Complaints and compliments shared learning
- Co-production of the complaints response template (Oct/Nov-22)
- Representation at all senior leadership appointments
- 15 steps

Care Quality Commission (CQC) Survey

The 2022 Survey of Women's Experiences of Maternity Services was the ninth national survey carried out and involved 121 NHS acute trusts in England:

When comparing SaTH's 2022 results to 2021:

- There was a decline in 2 questions. Important to note that neither of these questions were statistically worse than any other Trust Nationally. However, they will be a key area of focus improvement
- There were 6 questions where we performed at a significantly higher rate than other Trusts
- The section of questions relating to 'feeding' classed as 'better' than other Trusts
- In all other questions we performed 'as expected'

Saving Babies Lives (SBL)

The SBL care bundle is a national initiative, introduced in 2016, designed as a driver to address stillbirth and neonatal death by reducing variation in clinical management

We are fully compliant with all five elements of the SBL Care Bundle Version 2. The five sections are:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancy
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour
5. Reducing preterm birth

Compliance has been confirmed by NHSE/I from our data submissions

Maternity Incentive Scheme (MIS) – Clinical Negligence Scheme for Trusts (CNST)

- NHS Resolutions' MIS (CNST) is designed to support the delivery of safer maternity care
- The scheme incentivises Trusts' to deliver ten maternity safety actions
- The Women & Children's' Divisional team have demonstrated to the Trust Board and the Integrated Care Board (ICB) their compliance with all ten of the safety actions
- The evidence has been externally validated by our external maternity improvement advisor

Quality Visit Feedback from Health Education England (HEE) visit (Jan-23)

The Shrewsbury and Telford Hospital NHS Trust

Letter from Deputy Head of Nursing and Midwifery (Midlands)

‘On behalf of Health Education England, [we] would like to thank you for arranging today’s virtual quality visit. The Midwifery students experience at the trust was excellent. They felt welcomed and supported by the midwifery and wider multidisciplinary team. The year 3 students recognised the journey you have been on and felt their voices had been heard. It was good to speak to the Practice Assessors / Supervisors who clearly valued their students, identified learning opportunities, and gave timely constructive feedback. The educators had a clear passion for supporting the learners and drive for continual improvement. The support from the educators was valued and praised by both students and supervisors. You have clearly established an open culture for safety and improvement as both students and staff alike knew how and felt comfortable to raise concerns. All the students we spoke too would recommend the trust as a place to learn.

The team has clearly worked very hard to support students which is now making a positive impact on the student experience. Please do keep up the good work and well done to you and the team.’

Thank you. Any questions?