Shropshire Council

Date: Wednesday, 9 November 2022

Time: 2.00 pm

Venue: Fourth Floor Addenbrooke House - Addenbrooke House

Contact: Amanda Holyoak, Committee Officer
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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TO FOLLOW REPORT (S)

5 Ockenden Review Update (Pages 1 - 22)

To receive a verbal update on the Ockenden Review

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The Shrewsbury and Telford Hospital NHS Trust

Our Maternity Journey and Progress to Date

Joint Health Scrutiny Committee Meeting Telford & Wrekin Council

9th November 2022

Presenters:

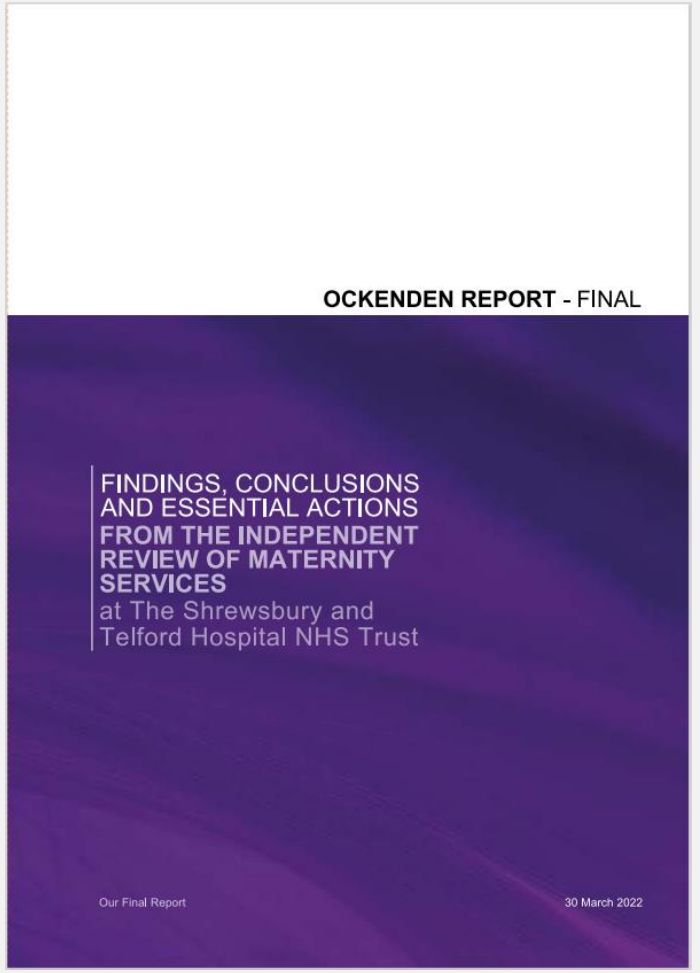
- Hayley Flavell – Executive Director of Nursing
- Annemarie Lawrence – Director of Midwifery

Agenda Item 5

Context

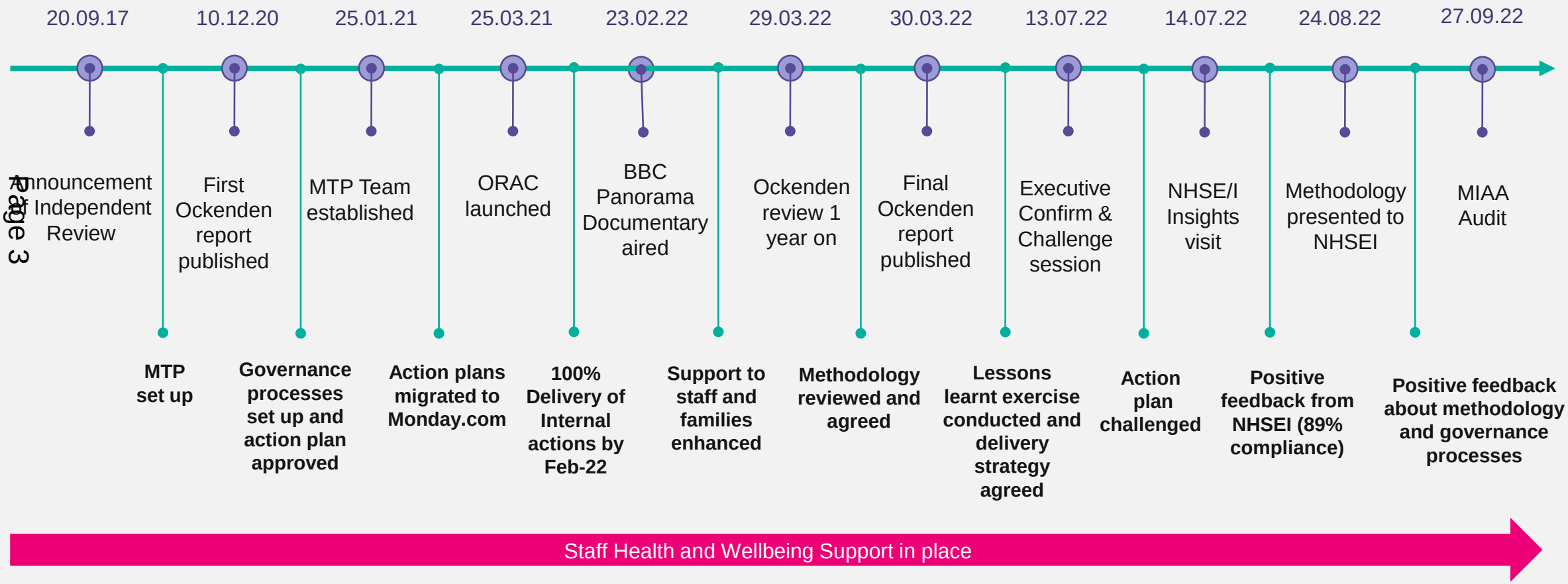
The Shrewsbury and Telford Hospital NHS Trust

- The Trust has received two Ockenden reports. The first, in December 20 with 52 actions, and the final, in March 2022, containing 158 actions. The Ockenden reports contain:
  - 93 Local Actions for Learning (LAFLs)
  - 22 Immediate and Essential Actions (IEAs) (117 sub-actions)
- These reports highlights significant failings at the Trust's maternity services and the impact this has had, and continues to have, on the families concerned. This must never happen again and the Trust must learn from its failings and address them without delay. The Chief Executive has apologised unreservedly to the families involved and has committed that the Trust will learn from their experiences.
- Improvement work is underway with the aim of ensuring the highest standards of maternity care and rebuilding the confidence and Trust of the community. The Trust must continue to implement actions contained in the first report, along with all new actions from the final report.
- On 11.10.2022, 108/210 total Ockenden actions have been delivered: from the first report 44/52, and from the final report 64/148 have been delivered.



High Level Summary Timeline of Events

The Shrewsbury and Telford Hospital NHS Trust



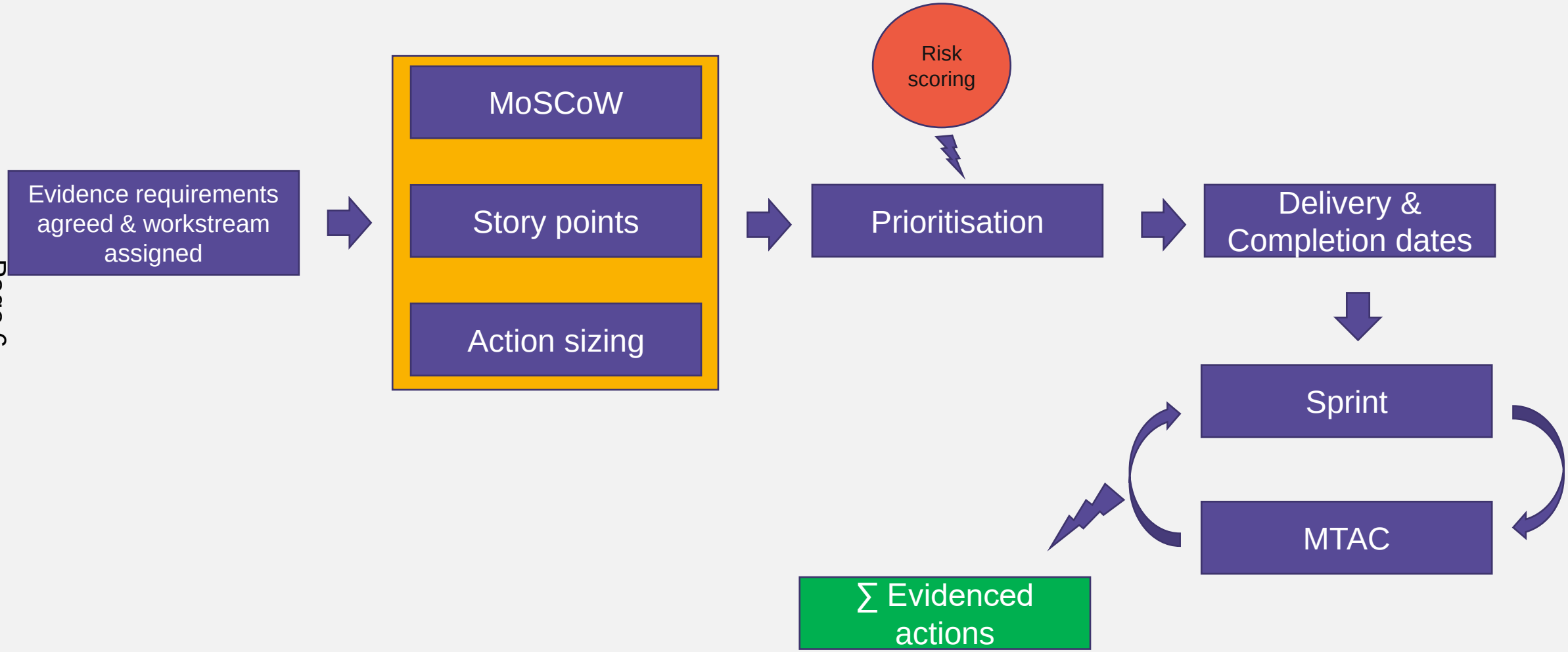
Our Approach

MTP 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

Methodology Process Map



Delivery & Progress Status: Reverse RAG Rating

The Shrewsbury and Telford Hospital NHS Trust

Delivery Status

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

Progress Status

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

Board Action Plan Example

The Shrewsbury and Telford Hospital NHS Trust

PROGRESS AS AT 09.08.2022

APPENDIX ONE

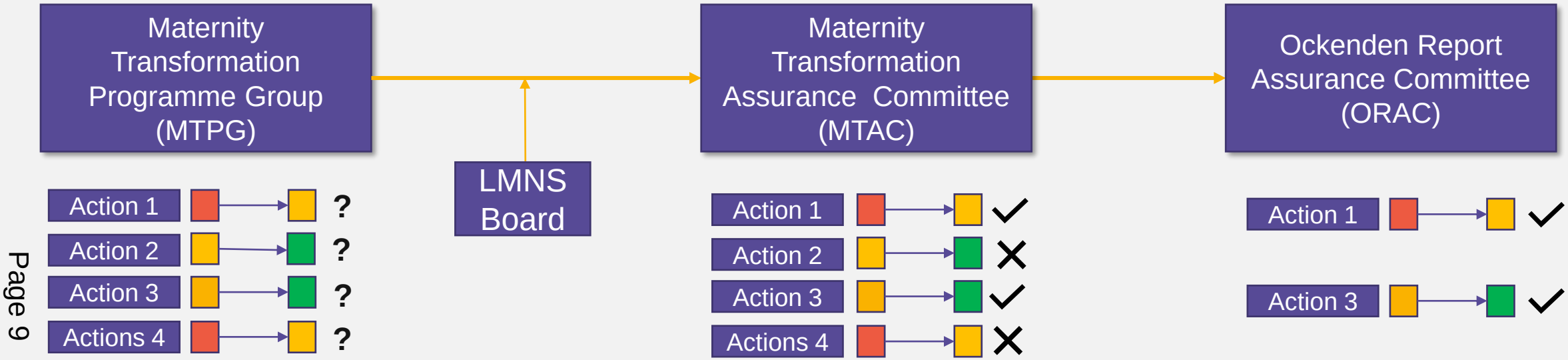
FINAL OCKENDEN REPORT ACTION PLAN

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	Not Started	Action pending further clarification before deadlines can be established.		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	Not Yet Delivered	On Track	This action comprises eight subactions. It is likely that they will be delivered by Nov-23, however; this will require an extensive piece of assurance work thereafter to embed fully and evidence, particularly as it covers such a wide range of staff groups. However, progress for this action is at 'on track' for delivery as work is already underway.		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	Not Yet Delivered	On Track	This action comprises three subactions. They will likely be delivered by Sep-22 and fully embedded by Jan-23.		31/01/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	On Track	This action comprises two subactions. They will likely be delivered by Sep-22 and fully embedded by Jan-23.		31/01/23		H. Flavell	A. Lawrence	
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	Not Yet Delivered	On Track	This action comprises two subactions. They will likely be delivered by Sep-22 and fully embedded by Jan-23.		31/01/23		H. Flavell	A. Lawrence	

Governance and Assurance Processes

The Shrewsbury and Telford Hospital NHS Trust



- Ockenden 'sprint' actions reviewed
- Evidence reviewed to take to MTAC
- If 'could/ shoulds' cannot be delivered - SRO has authority to approve exception
- Exception reports reviewed
- Finance/operational aspects discussed

- Ockenden actions due presented and accepted/rejected as delivered or evidenced.
- Exception reports accepted/rejected.
- 'Sprint' delivery overview.
- Act upon escalated risks & issues.

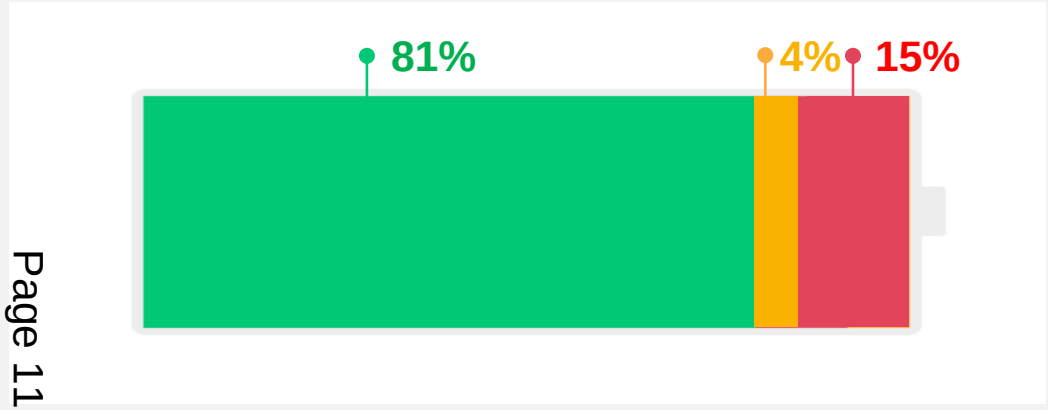
- To provide assurance of Ockenden completion
- Sub committee of Board of Directors
- Independent co-chair
- Live-streamed to public

Results and Achievements

Completion Batteries – Ockenden Reports

The Shrewsbury and Telford Hospital NHS Trust

First Ockenden Report

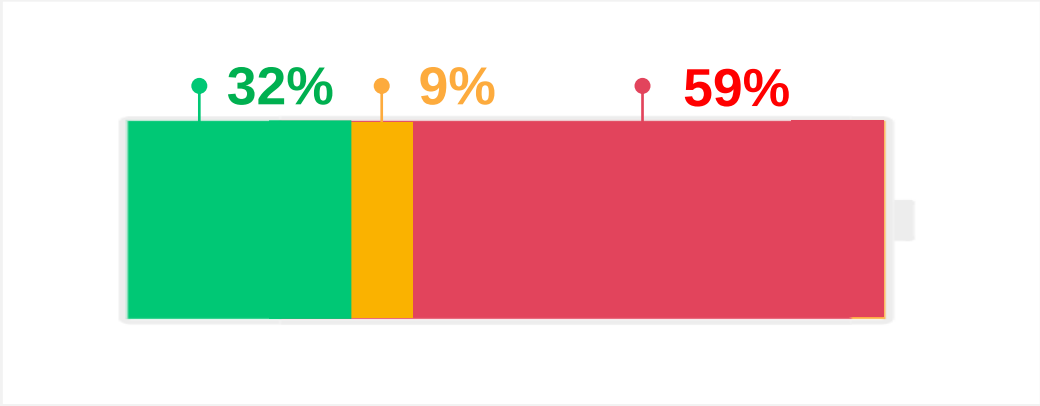


44/52 Actions Implemented (85% overall), comprising:

- 42 (81%) green – ‘Evidenced & Assured’
- 2 (4%) amber – ‘Delivered, Not Yet Evidenced’

8 (15%) Actions ‘not yet delivered’. Of these, 3 are ‘on track’ and 4 are ‘off track’, and 1 is ‘at risk’.

Final Ockenden Report



64/158 actions implemented (41% overall) comprising:

- 50 (32%) green – ‘Evidenced and Assured’
- 14 (9%) amber – ‘Delivered, not yet evidenced’

From the 94 actions (59%) ‘Not yet Delivered’, 58 actions (37%) are ‘On Track’ for progress

Improvements and Impact

The Shrewsbury and Telford Hospital NHS Trust

Issue	Impact/ Changes
Not Listening to Women and Families	• Family involvement in incident investigations, for both Serious Incidents (SI's) and HSIB cases • Improved relationships with the Maternity Voices Partnership • CQC Maternity Survey – SATH performing 'Better than Expected' in 2021 results, which is based on direct feedback from women • Implemented user-experience workshops – topics selected by women, with defined outcomes
Management of Birth Options for Women/ Risk Management	• Birth Options clinics introduced • Improved management of women at risk of premature labour/birth. Named consultant for 'high risk' pregnancies • 100 midwives and doctors undertaking extended training to manage women with complex pregnancies • Escalation and clear guidance on when a consultant must attend, which goes further than RCOG • Introduced 'Birth Preferences Guide' to help women reach an informed decision • Consultants resident 24/7 to manage complex pregnancies

Improvements and Impact cont.

The Shrewsbury and Telford Hospital NHS Trust

Issue	Impact/Changes
Poor Management of Patient Safety Incidents	• Managed and overseen corporately by executive directors • Independent input to incident classification and management (PMRT, SI's, HSIB, etc) • Incident management aligned with national standards • Learning from incidents shared across the trust and can feed in to special interest groups for wider learning • We will implement the new national incident management framework (PSIRF)
Consultant Obstetricians On-call from Home	• 24/7 on-site presence of consultant obstetrician • Twice day multidisciplinary ward rounds on delivery suite: a clear & written plan for every woman • Consultant physical presence at complex deliveries i.e. breech, twins, high BMI, Caesarean Sections, etc.
Outdated Practices/ Techniques	• PROMPT training – emergencies and CTG (Electronic Fetal Monitoring) training • Improved competency package for CTG/Electronic Fetal Monitoring training • Two fetal monitoring specialist midwives and a lead consultant employed • New electronic learning management system • Full delivery of the Saving Babies Lives Care (v2) Care Bundle – improved standards to help reduce stillbirths

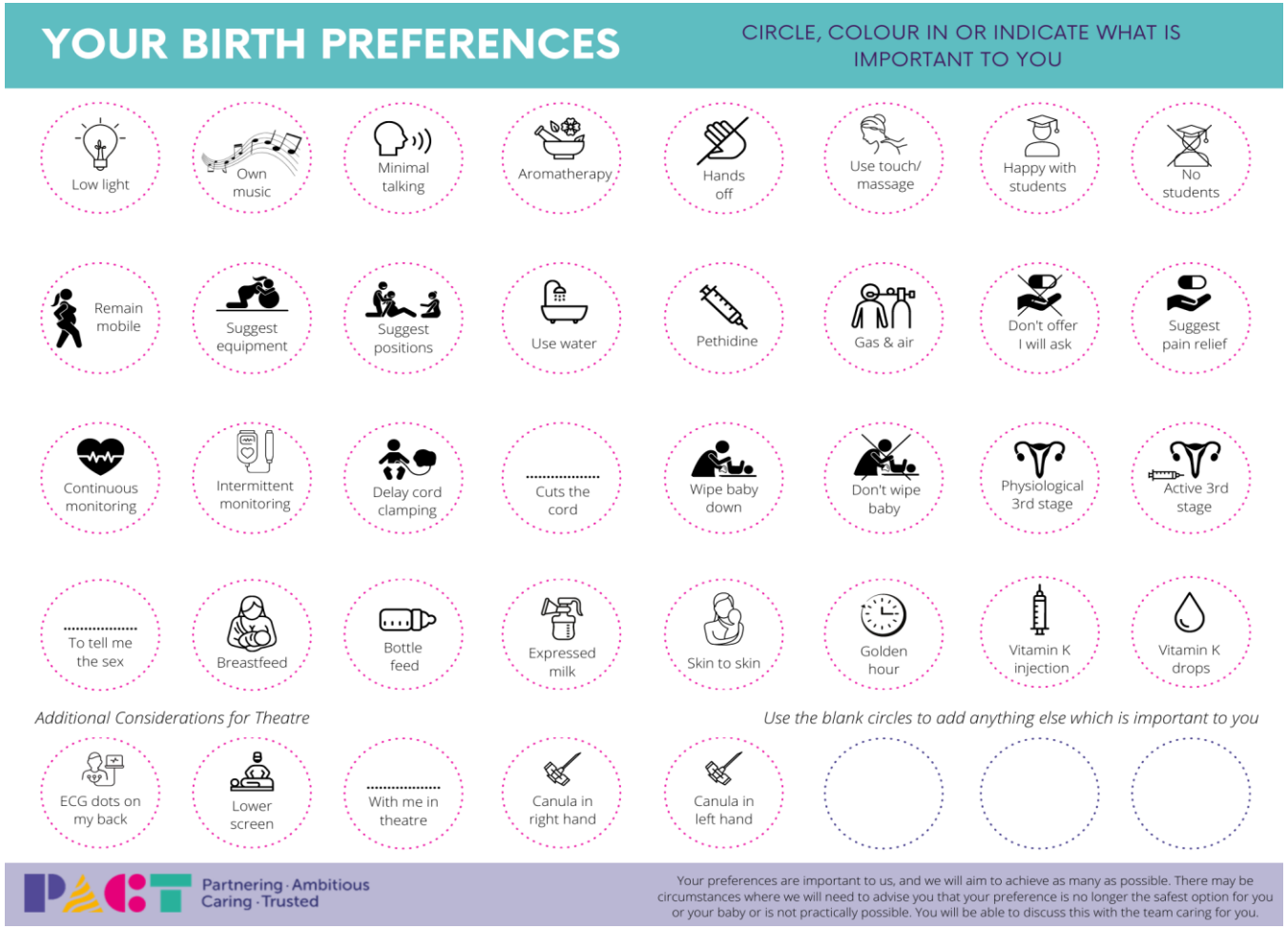
Improvements and Impact cont.

The Shrewsbury and Telford Hospital NHS Trust

Issue	Impact/Changes
Poor Bereavement Support	• Lead consultant appointed and additional Bereavement midwife recruited • Recent positive assessment by the Stillbirth and Neonatal Death Society (Sands) • Rainbow Clinics – care of women and families following bereavement
Cultural/ Leadership Issues	• New executive directors and new members of senior W&C team – leading by example • Support from other Trusts – UHB, SFH, and experts - NHSEI • Corporate cultural change programme • Improved culture of escalation and transparency • Calling out poor behaviour • Supported staff to complete leadership and coaching courses
Midwifery Staffing Levels	• Midwifery establishment funded to latest Birthrate Plus standard • Introduction of maternity support workers • Enhanced neonatal nurse staffing

Making a Difference

MVP Co-production Work - Birth Preferences Card



The Birth Preferences Card was launched earlier this year and was co-produced with the Maternity Voices Partnership (MVP).

Aim:

- ✓ To empower women and birthing people to have more conversations about their preferences.
- ✓ To ensure they feel fully supported during their birth experience.

Next Steps

Next Steps

- 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.

External Feedback Received

The Shrewsbury and Telford Hospital NHS Trust

‘The level of clinical and operational engagement comes through really strongly’ (Sylvia Knight, Director of Nursing, NHSEI. March 2022.)

[SaTH described as a] ‘shining example following the Ockenden assurance visit’ (Regional Perinatal Quality Committee, July 2022.)

‘These positive comments are reflected in comments we have previously had from our medical students and postgraduate medical learners too’ (Andy Whallett, Health Education England. 2021.)

SATH one of seven trusts performing “better than expected” (CQC National Maternity Survey 2021, May 2022.)

Our aim is to continue on our improvement journey to ensure we deliver the highest standards of maternity care and rebuild the confidence and trust of our community.

Thank You. Any Questions?