Ockenden Report Assurance Committee (ORAC)

Methodology Overview and Overall Position of 210

Ockenden actions

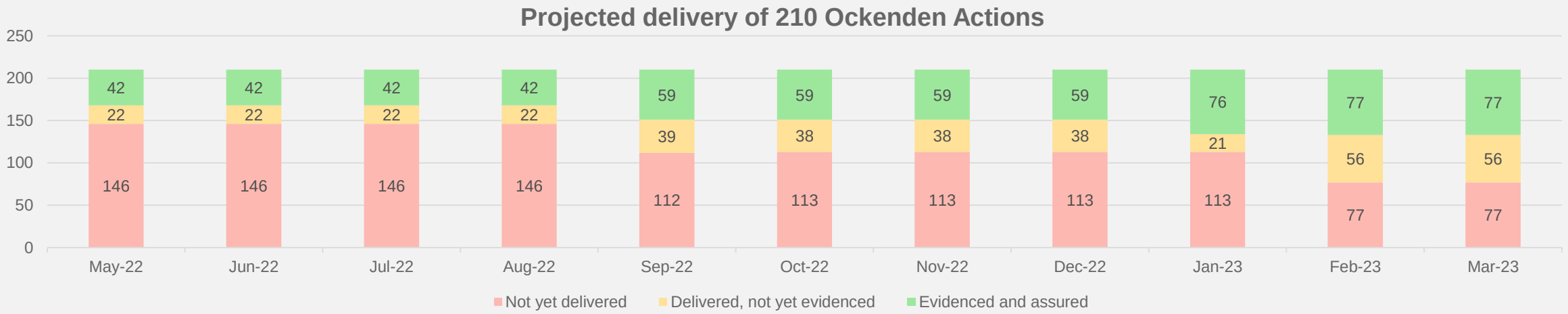
Date: 28.02.2023

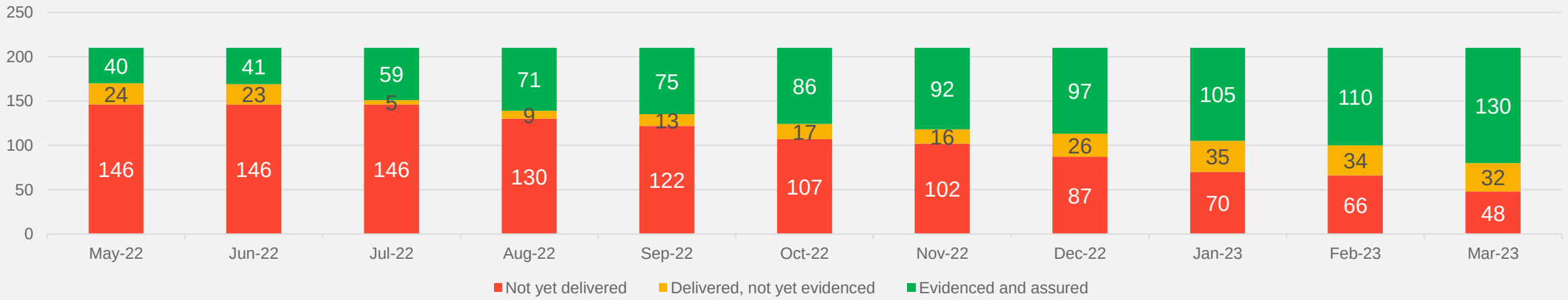
Presenter:

- Carol McInnes – Director of Operations, W&C

Assurance: Projected vs. Actual Delivery

The Shrewsbury and Telford Hospital NHS Trust





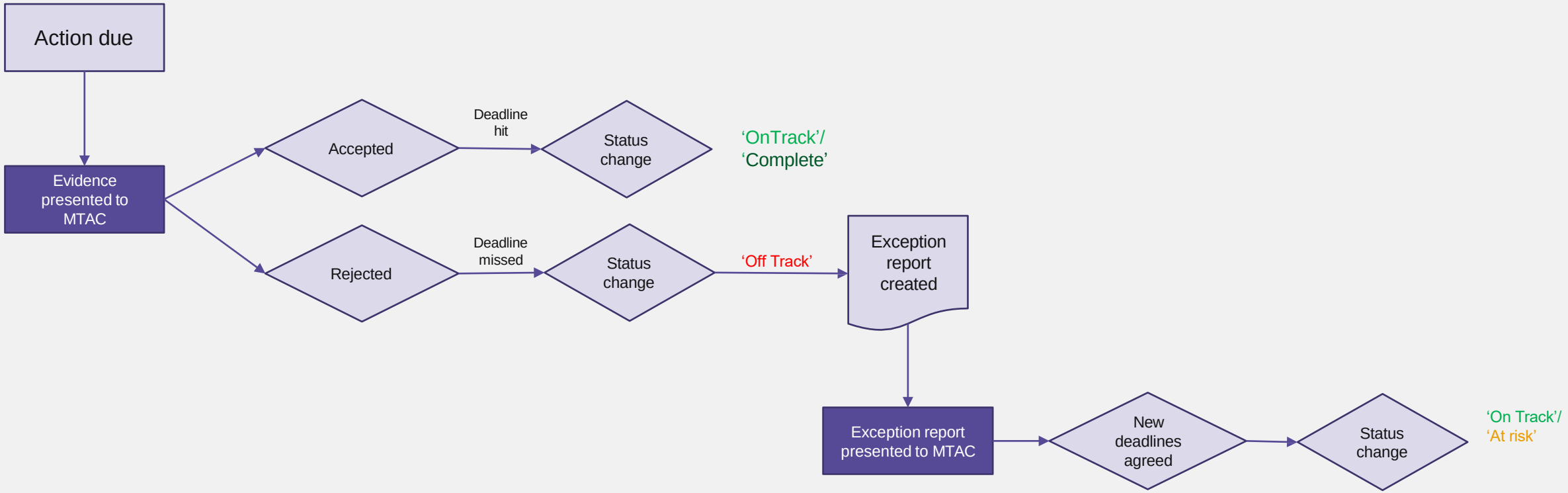
Approaching 1 year after the Publication of the Final Ockenden Report

- The final Ockenden Report was published in March 2022
- Since then, the Divisional Senior Teams have worked hard to deliver numerous actions following a clinical prioritisation review
- A Senior Leadership MTP Workshop was held in January 2023 where all red ‘not yet delivered’ actions were reviewed in detail. It was noted that a number of these, were actions which could not be delivered by the Trust, as they were either fully outside our control or scope of work
- Definition of ‘de-scope’ reverse RAG progress status: The work to deliver this action sits outside the scope of the programme or cannot be delivered by the programme. An exception report must be created to explain why, along with mitigating actions. All de-scoped actions must be reviewed periodically
- Following that workshop, the team identified a total of 10 actions meeting the ‘de-scope’ criteria

Exception Reports: Process Reminder

The Shrewsbury and Telford Hospital NHS Trust

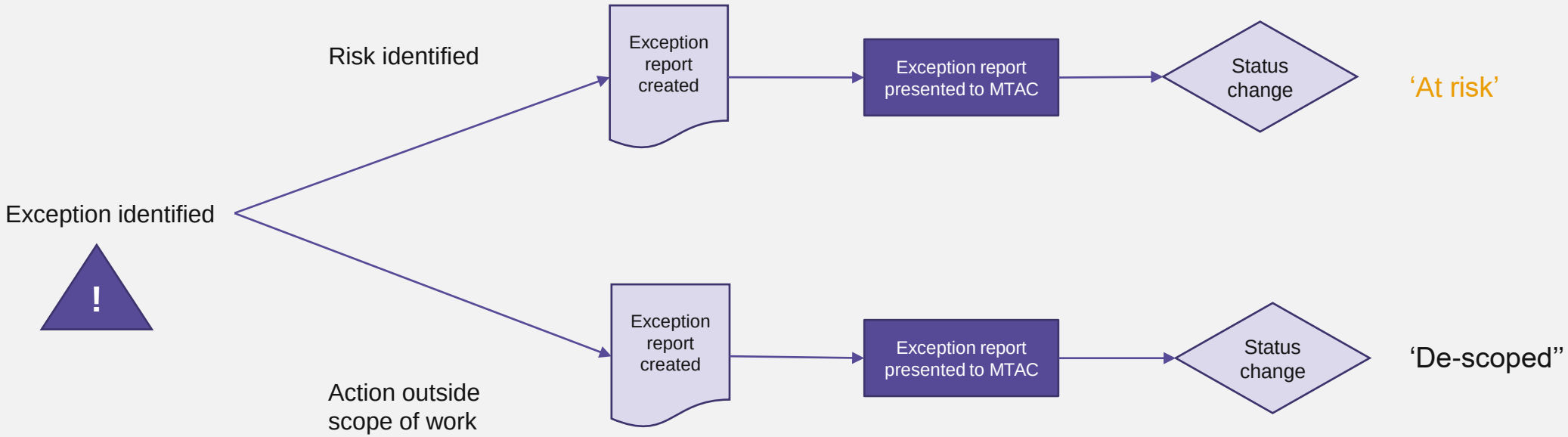
Scenario 1: When evidence is rejected and deadline missed



Exception Reports: Process Reminder

The Shrewsbury and Telford Hospital NHS Trust

Scenario 2: When action is flagged ‘at risk’ or out of scope



PMP definition of ‘out of scope’: Work that is beyond the current scope of a project. Project scope defined as the work that needs to be accomplished to deliver a product, service or result with the specified features or functions.

Example of a ‘De-scoped’ Action

The Shrewsbury and Telford Hospital NHS Trust

ID	Theme	Description	Progress status change approved
IEA 1.7 (Final Report)	Resources (training programme)	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.	

Example of Exception Report – IEA 1.7

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Requirements Implementation: Exception Report							
Date of Report:	07.02.2022	**Ockenden ID:**	IEA 1.7	**Delivery Status:**	**Not yet Delivered**	**Progress Status:**	**De-scoped**
Executive Lead:	H. Flavell	**Requirement:**	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.				
Action Lead:	A. Lawrence						

Reason for exception and consequences	**Mitigation**
• Action states all labour ward coordinators must attend nationally recognised labour ward coordinator education module. • Currently, there is no Nationally recognised labour ward coordinator programme. Therefore, lies outside our control and the action lies outside MTP scope of work.	In the interim, the following is in place: • In-house band 7 midwifery development programme • Delivery Suite/ Triage coordinator competency/ orientation programme which includes RCM modules
Recommendation	**What lessons have been learnt from this exception?**
• MTPG recommend that MTAC accepts this action as 'de-scoped'	To review all Ockenden actions throughout project lifetime to ensure actions remain within scope
Original delivery and assurance date:	May-23 and Aug-23
Proposed delivery and assurance date:	Maintain May-23 and Aug-23

48/210 Red ‘Not Yet Delivered’ Actions: Breakdown

The Shrewsbury and Telford Hospital NHS Trust

First Report: 5 actions:

- 1 neonatal action (ANNPs rotating to tertiary unit) **‘On Track’**
- 4 external actions (LMNS, CQC, NHSEI). **1 ‘On Track’, 2 ‘Off Track’** and **1 ‘De-scoped’**

Final Report: 43 actions:

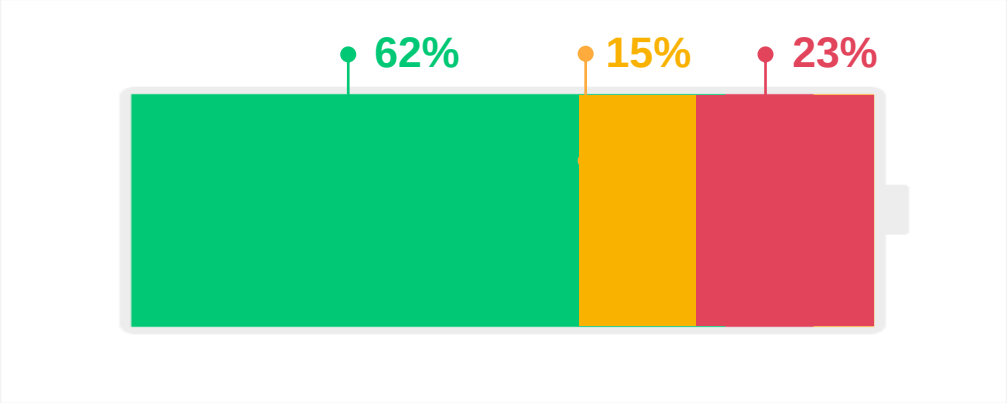
- 12 external actions: **6 ‘On Track’** and **6 ‘De-scoped’** (LMNS, NHSE/I, Royal colleges)
- 31 internal actions: **2 ‘Not Started’, 2 ‘De-scoped’** and **27 ‘On Track’** (L and XL actions). Actions mostly linked to governance and workforce

Rationale for ‘de-scoped’ progress status covered on next slides.

Combined Ockenden Report – Completion Batteries

The Shrewsbury and Telford Hospital NHS Trust

Delivery Battery

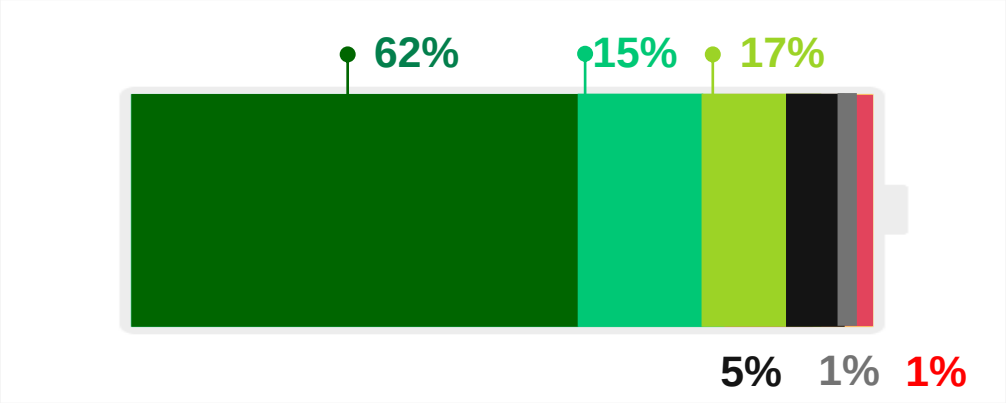


162/210 Actions Implemented (77% overall), comprising:

- 130 (62%) 'Evidenced & Assured'
- 32 (15%) 'Delivered, Not Yet Evidenced'

48 (23%) Actions 'Not Yet Delivered'. Of these, over two thirds are underway.

Progress Battery



- 130 (62%) 'Complete'
- 31 (15%) 'Embedding'

- 2 (1%) 'Off Track'
- 2 (1%) 'Not Started'
- 35 (17%) 'On Track'
- 10 (5%) 'De-scoped'

Thank You. Any Questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

Ockenden Action Plan Update (First Report)

Date: 28.02.2023

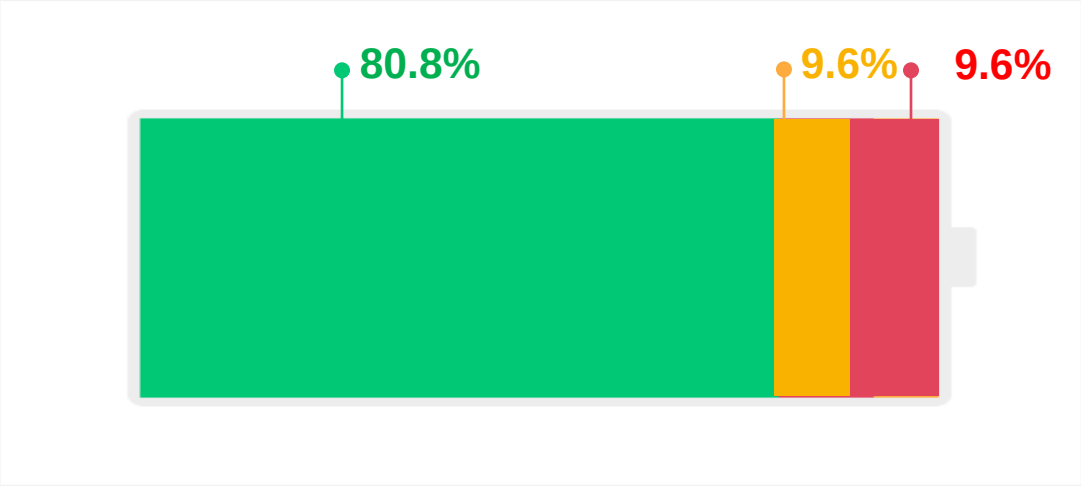
Presenter:

- Kim Williams – Deputy Director of Midwifery

First Report - Completion Battery

The Shrewsbury and Telford Hospital NHS Trust

Delivery Battery

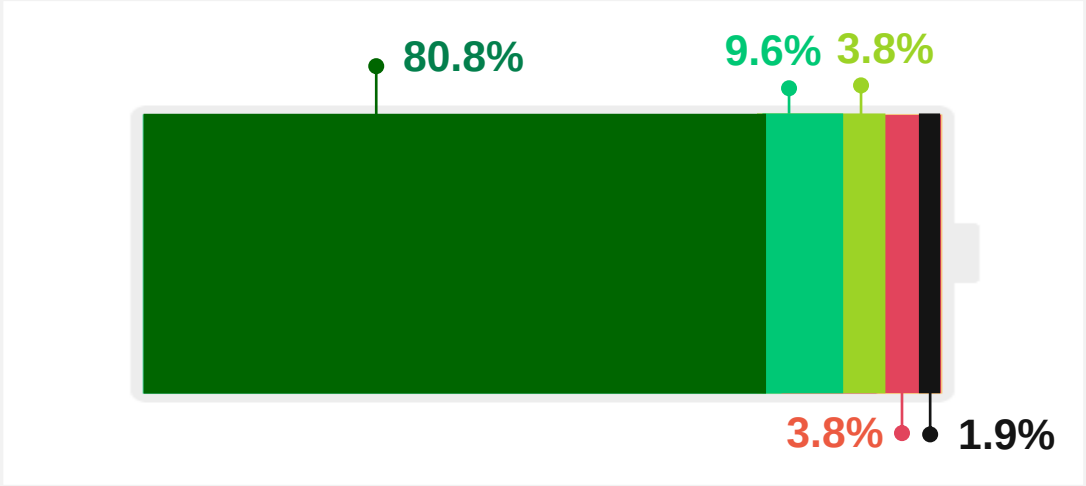


47/52 Actions Implemented (89% overall), comprising:

- 42 (81%) ‘Evidenced & Assured’
- 5 (10%) ‘Delivered, Not Yet Evidenced’

5 (10%) Actions ‘Not Yet Delivered’

Progress Battery



- 42 (81%) ‘Complete’
- 5 (10%) ‘Embedding’
- 2 (4%) ‘Off Track’
- 2 (4%) ‘On Track’
- 1 (2%) ‘De-scoped’

‘Not Yet Delivered’ – Red Actions

The Shrewsbury and Telford Hospital NHS Trust

ID	Dependent	Reasons	Deadline	Progress
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 womens’ 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	De-scoped

Advancements at Feb-23 MTAC

Action accepted as amber ‘delivered not yet evidenced’ / ‘embedding’

ID	Theme	Description	Delivery status change approved
LAFL 4.88	Governance (Anaesthetics escalation to on-call consultant SOP)	Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Action accepted as ‘de-scoped’ for progress

ID	Theme	Description	Progress status change approved
IEA 2.4	CQC inspections	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.	

Summary (First Report)

- 47/52 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.
- 5 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 and 2.2 set as ‘Off Track’ until clear timeframes can be provided, and IEA 2.4 ‘de-scoped’.

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

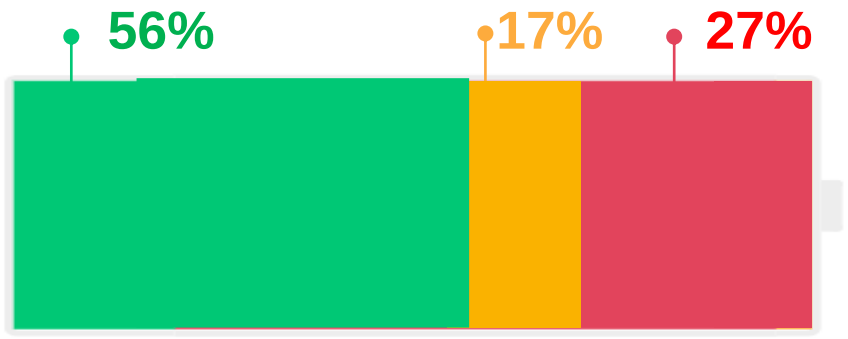
Presenter:

- Annemarie Lawrence, Director of Midwifery

Final Report – Completion Battery

The Shrewsbury and Telford Hospital NHS Trust

Delivery Battery

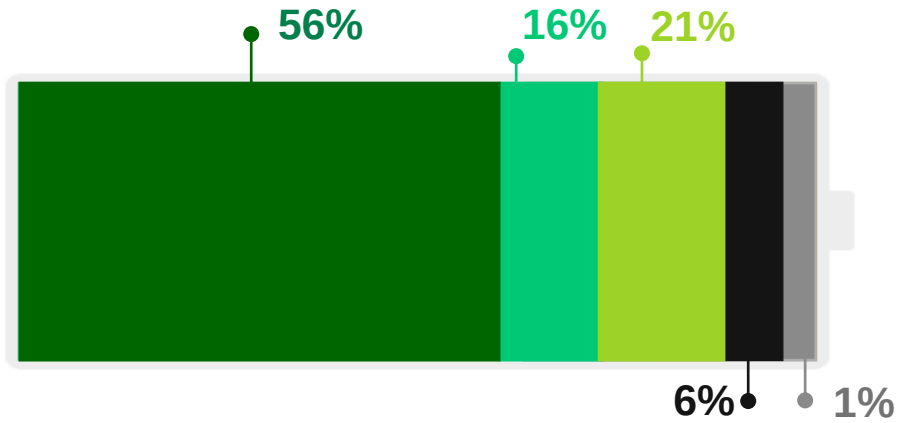


73% implemented (115/158 actions) as of Feb-23 MTAC.

- 88 actions (56%) green – ‘Evidenced and Assured’
- 27 actions (17%) amber – ‘Delivered, Not Yet Evidenced’

43 actions (27%) ‘Not yet Delivered’

Progress Battery



- 88 (56%) ‘Complete’
- 26 (16%) ‘Embedding’
- 22 (21%) ‘On Track’
- 9 (6%) ‘De-scoped’
- 2 (1%) ‘Not started’

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘amber’ – ‘delivered not yet evidenced’

ID	Theme	Description	Delivery status change approved
IEA 8.4	Complex antenatal care	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman’s maternity records.	
IEA 8.5	Complex antenatal care	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	
IEA 9.4	Preterm birth	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘amber’ – ‘delivered not yet evidenced’

ID	Theme	Description	Delivery status change approved
IEA 11.5	Safe staffing (anaesthetics)	Obstetric anaesthesia staffing guidance to include: The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	
IEA 11.6	Safe staffing (anaesthetics)	Obstetric anaesthesia staffing guidance to include: The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity	
LAFL 14.54	Governance (audit against guideline compliance)	The Trust’s anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘green’ – ‘Evidenced and Assured’

ID	Theme	Description	Delivery status change approved
LAFL 14.4	Serious Incidents policy	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.	
LAFL 14.7	Incident investigation training	All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months	
LAFL 14.8	Incident investigation reports	The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘green’ – ‘Evidenced and Assured’

ID	Theme	Description	Delivery status change approved
LAFL 14.23	Audits of guidelines	A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.	
LAFL 14.51	Workforce (anaesthetics)	The Trust’s executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.	
LAFL 14.63	Ongoing assurance of improvements	Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘green’ – ‘Evidenced and Assured’

ID	Theme	Description	Delivery status change approved
IEA 11.3	Governance (anaesthetics)	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	
IEA 1.6	NQM training	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	
IEA 1.8	Orientation package	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘green’ – ‘Evidenced and Assured’

ID	Theme	Description	Delivery status change approved
IEA 5.1	Use of language (investigation reports)	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms	
IEA 6.2	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. This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	
IEA 8.2	Multiple pregnancy	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘green’ – ‘Evidenced and Assured’

ID	Theme	Description	Delivery status change approved
IEA 15.1	Mental health	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate	
IEA 15.2	Mental health	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	
IEA 15.3	Mental health	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘green’ – ‘Evidenced and Assured’

ID	Theme	Description	Delivery status change approved
IEA 12.4	Safe staffing	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	
IEA 2.8	Leadership development	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	
IEA 2.10	Safe staffing	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘green’ – ‘Evidenced and Assured’

ID	Theme	Description	Delivery status change approved
IEA 5.5	Incident investigations	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	
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.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Action accepted as ‘de-scoped’ for progress

ID	Theme	Description	Progress status change approved
IEA 1.1	Resources (NHSE/I Funding)	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.	
IEA 1.4	Bodies reviewing methodology	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	
IEA 1.7	Resources (training programme)	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.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Action accepted as ‘de-scoped’ for progress

ID	Theme	Description	Progress status change approved
IEA 1.11	Resources (Training programme)	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.	
IEA 6.1	NHSEI, Royal colleges and chief coroner review panel	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. 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	
IEA 11.4	Resources	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.	

Advancements at Feb-23 MTAC

The Shrewsbury and Telford Hospital NHS Trust

Actions accepted as ‘de-scoped’ for progress

ID	Theme	Description	Progress status change approved
IEA 14.5	Resources	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace. Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	
LAFL 14.1	PSIRF roll out	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.	
LAFL 14.64	Resources	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.	

Summary (Final Report)

Summary (Final Report)

The Shrewsbury and Telford Hospital NHS Trust

- From the final report, 115/158 have now been ‘delivered’ (73%). From the 27% ‘not yet delivered’, over two thirds of these are underway
- We are ahead of schedule for delivery and have focused on those higher risk scored initially, as part of our prioritisation process
- Over the coming months, our focus will be on those larger, more complex actions, that we now need to deliver upon
- The Division’s can provide assurance that work continues at pace to deliver the rest of the programme

Thank You. Any Questions?

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

February 2023

Listening to women and families – Focus on MVP (15 steps) and Maternity and Neonatal Safety Champions

Presenter:

- Angela Loughlin – Maternity Voices Partnership (MVP) Development Co-ordinator
- Fiona McCarron – Consultant Midwife
- Claire Eagleton – Deputy Director of Midwifery

15 Steps

Introduction

The Shrewsbury and Telford Hospital NHS Trust

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices

Working in partnership to improve maternity services

NHS

Working group

Service Users and Families

Commissioners and Providers (Midwives and Doctors)

Development of Local Maternity Care

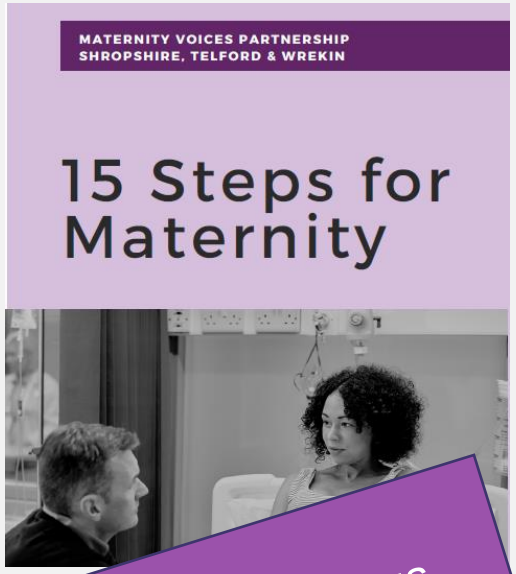
Introduction

The Shrewsbury and Telford Hospital NHS Trust

Your Experience Matters.

Your Voice Matters.

Your Input Matters.



Your Feelings Matter.

Introduction

The Shrewsbury and Telford Hospital NHS Trust

Expert Clinical Practice

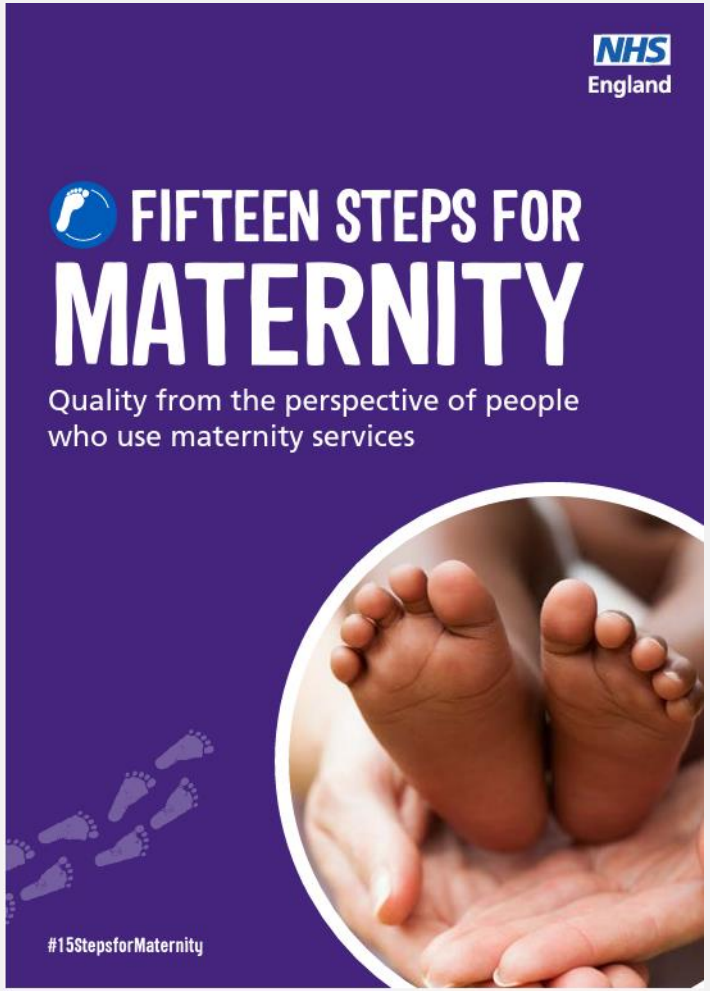
Clinical and Professional Leadership

Consultant Midwife

Research and Education

Practice and Service Development

Context: 15 Steps



"I can tell what kind of care my daughter is going to get within 15 steps of walking onto every new ward"

15 Steps from MVP Perspective

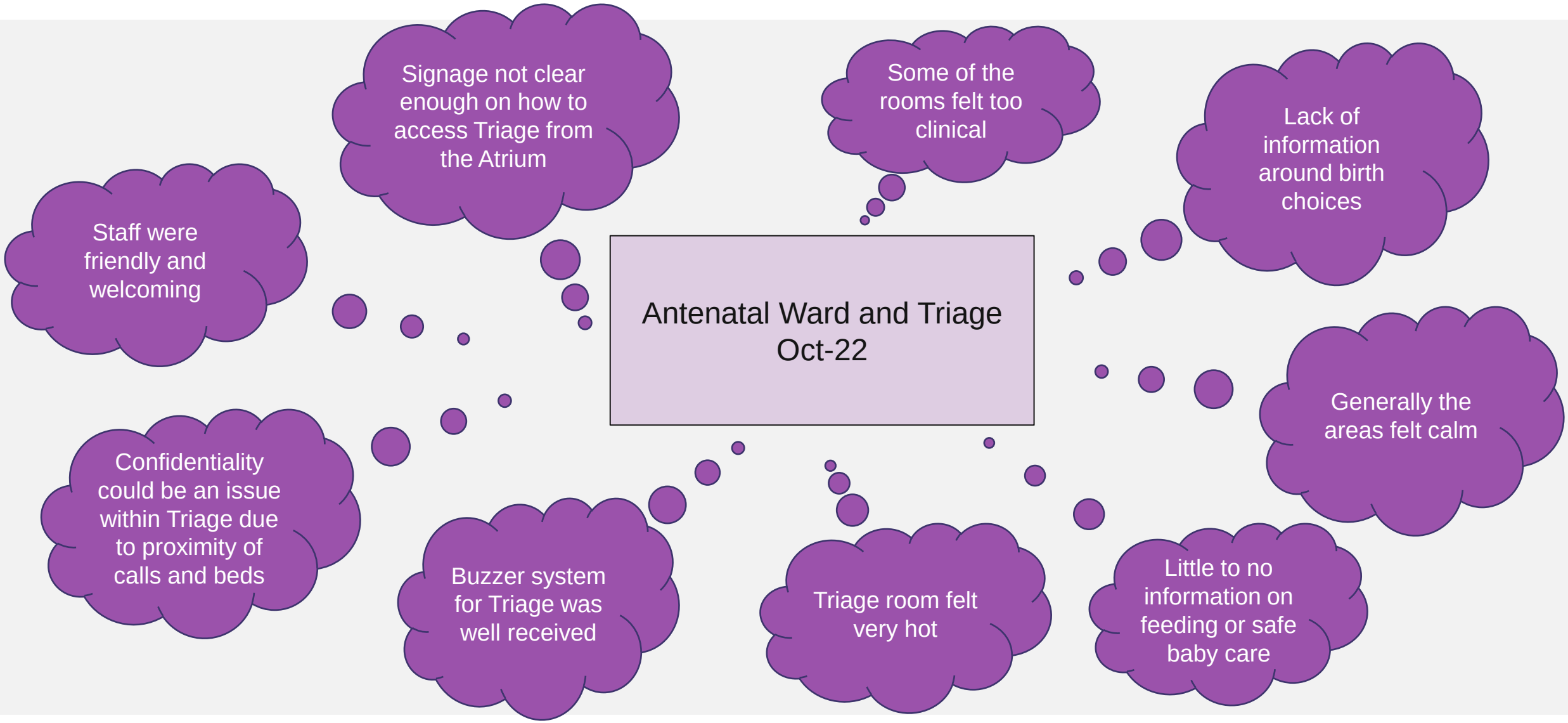
The Shrewsbury and Telford Hospital NHS Trust

- Welcoming and Informative
- Safe and Clean
- Friendly and Personal
- Organised and Calm

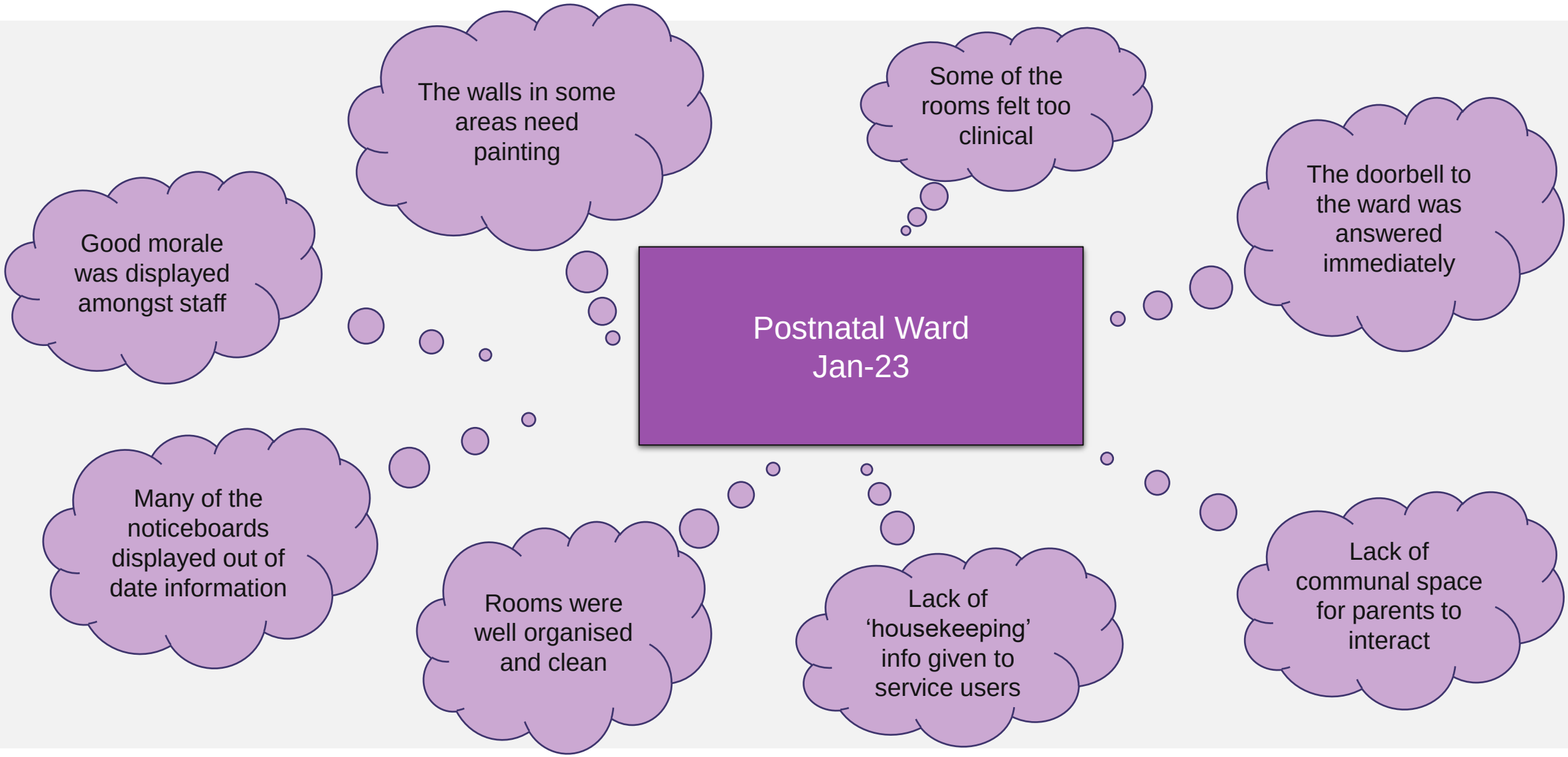
15 Steps from SaTH's Perspective

- Provides valuable knowledge, experience and insights
- Leads to service innovation and improvement and operational efficiencies
- Service users feeling listened to and involved, which helps contribute to safer care
- NHS Long Term Plan (2019) is explicit about setting the environment where the service-users' voice is valued

15 Steps in Action – Oct-22 Event



15 Steps in Action – Jan-23 event



Our Approach

The Shrewsbury and Telford Hospital NHS Trust

- When we receive a report, we consolidate the positive feedback and share this with our staff
- Where there are areas noted for improvement, we will review our current plans within our MTP workstreams to see if this suggestion is already in progress (for example, lack of information around birth choices, is being addressed via workstream 1 and 5)
- Where there are areas identified for rapid improvement, these are implemented by the Divisional leadership team (for example, noticeboards with out of date information)
- New suggestions are added to the overarching 15 Steps action plan on Monday.com to ensure delivery of the suggested ideas for improvement

Jul-22 Event - Delivery Suite

Item	Person	Status	Category
Add stickers to the floor of the atrium to direct to diff...	FM	Stuck	Area for Develop...
video walkthrough from the car park	FM	Done	Positive area
move the welcome board to a more central viewpoint	FM	Working on it	Area for Develop...
soften the delivery suite rooms to create a calm envir...	FM	Done	Positive area
produce A3 birth preferences posters for display	FM	Done	Positive area
birth positions and coping strategies posters to be dis...	FM	Done	Positive area
investigate the hearing loop availability	FM	Working on it	Area for Develop...
clarify purpose of the bump borders in the corridors	FM	Working on it	Area for Develop...
uniform explanation board or poster on display	FM	Working on it	Area for Develop...
Review notice boards and remove acronyms	FM	Done	Positive area

Examples of Improvements

The Shrewsbury and Telford Hospital NHS Trust

Some of the ideas suggested from previous 15 Steps events that have been implemented to date include:

- ✓ Maternity web page now includes a video walkthrough from the carpark, through the atrium to the Delivery Suite
- ✓ Lights with Bluetooth speakers and soft glow now in place on Delivery Suite
- ✓ Triage phonelines relocated to a private office
- ✓ Wall murals agreed and produced – currently awaiting delivery
- ✓ Trust redecoration programme will add softer colours to birthing rooms and relocation of the welcome board
- ✓ Large Birth Preferences Posters in each birthing room, which include support people's names
- ✓ Awaiting delivery of wall posters to promote a range of different coping strategies and labour/birth positions
- ✓ Noticeboards on Delivery Suite reviewed and acronyms removed

Conclusion

The Shrewsbury and Telford Hospital NHS Trust

https://shroptwmaternityvoices.co.uk/

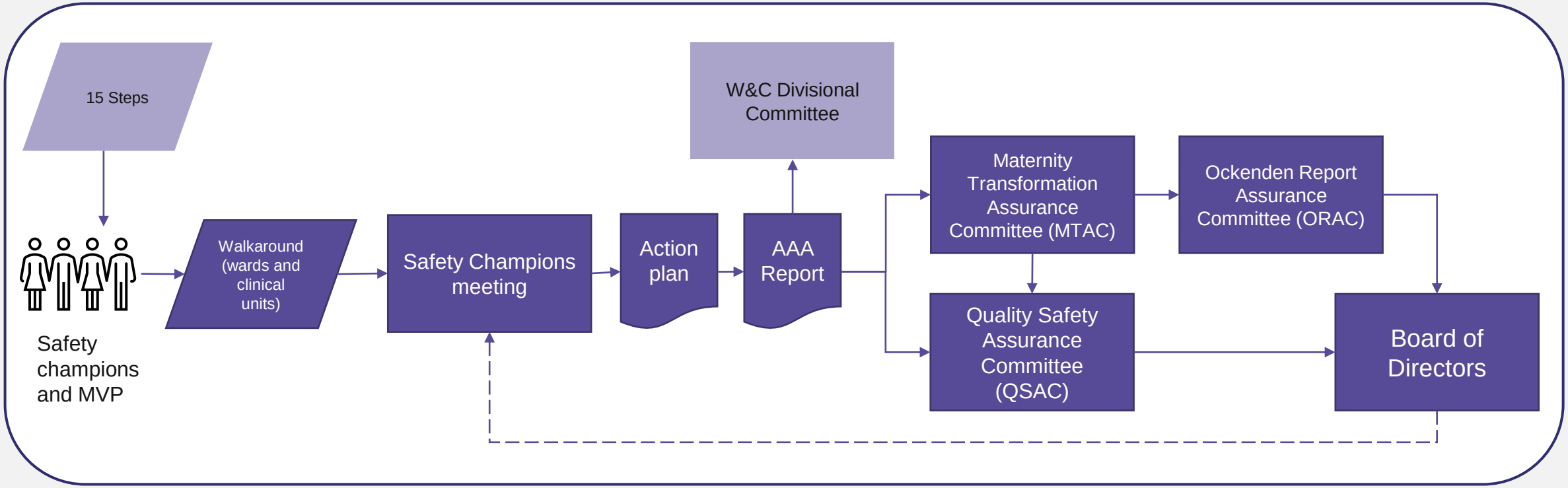
Maternity and Neonatal Safety Champions

Presenter: Carol McInnes

Introduction

The Shrewsbury and Telford Hospital NHS Trust

Linking 15 steps to Safety Champions and the Ward-to-Board process



Thank you

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Assurance Committee (ORAC)

February 2023

Communications plan update

Presenters:

- Charlotte Robertshaw – Communications and Engagement Manager for Maternity Services
- Katie Steyn – Communications and Engagement Manager for Maternity Services

The Vision for our Communication Plan

The Shrewsbury and Telford Hospital NHS Trust

1. To instil confidence amongst our women and their families, so they feel safe and secure using our services

2. To improve staff morale so they feel valued and proud to work in our Trust

Audiences:

- ✓ Women and families
- ✓ Maternity staff
- ✓ Local community
- ✓ Stakeholders
- ✓ Trust-wide staff

Our Response

The Shrewsbury and Telford Hospital NHS Trust

1. Modernisation of our digital channels
- Website
- Social media
- Digital screens

+

2. Engaging with the media
- Regular press releases
- Enabling colleagues to talk to the media
- Opening our doors to the media

+

3. Engaging with families and colleagues
- Website
- Social media
- Digital screens
- ImproveWell
- ORAC videos
- Working with our MVP

+

4. Regular updates on improvement work
- Press releases
- Website
- Social media
- Digital screens
- ORAC
- Public meetings

=

Better experience for staff and families
- ✓ Confidence
- ✓ Feeling valued
- ✓ Transparency
- ✓ Being informed
- ✓ Feeling listened to and involved

1. Modernisation of our Digital Channels

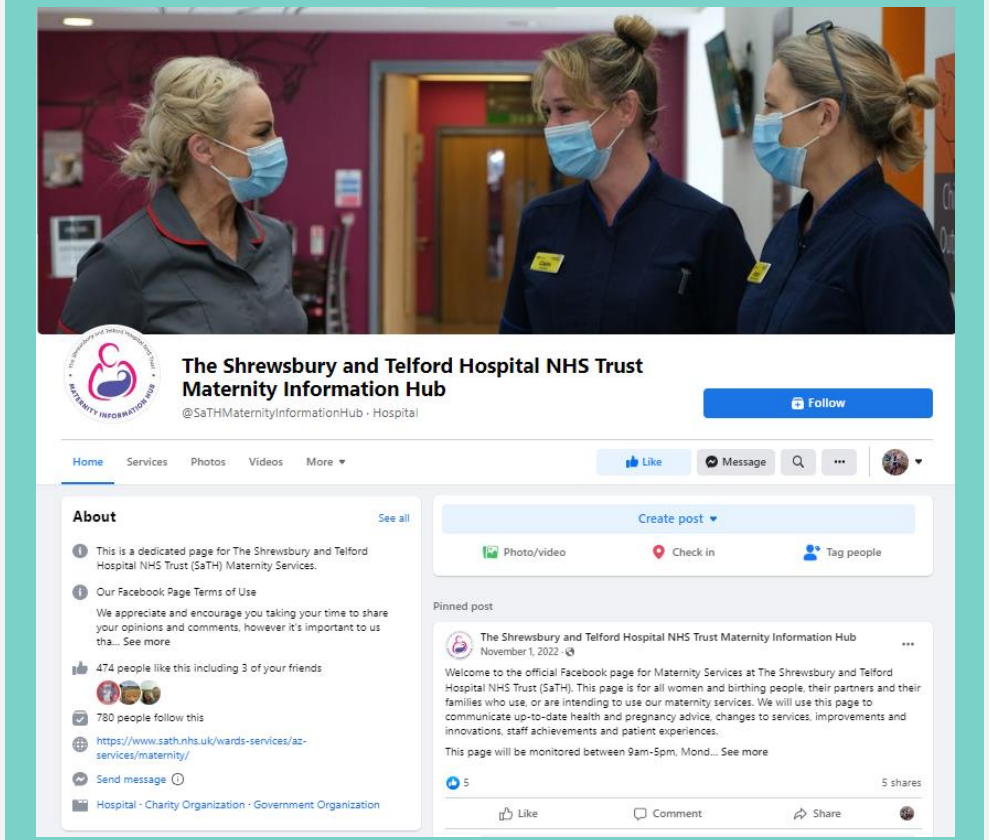
Digital Channels

The Shrewsbury and Telford Hospital NHS Trust

Our service users are: young, interact digitally, are active on social media and search for information online.

The digital footprint of our maternity services can be the first impression on our audiences. Therefore, focus has been made on the following:

- ✓ **New website.** This will modernise our external image and reflect the modern service we provide
- ✓ **Digital screens.** These serve as a useful communication tool and have been installed in different areas
- ✓ **Social media.** We launched a Facebook page in October 2022, which has already gained more than 1,250 followers



2. Engaging with the Media

Proactive, Not Reactive

- ✓ To be open, honest and transparent in all communication
- ✓ To share service updates, improvement work, innovations and achievements with local media
- ✓ To engage, provide information and statements in response to maternity media enquiries
- ✓ To build a positive and productive relationship with the media
- ✓ To ensure the coverage of our services is balanced to build and then retain the confidence of local communities.

Proactive Communications

The Shrewsbury and Telford Hospital NHS Trust

News releases

First Midlands research collaboration to focus on patient safety, benefitting local maternity service users

Maternity services staff celebrated for providing good care

Trust named outstanding outlier in national delayed cord clamping audit

Results of Care Quality Commission 2022 maternity survey published

Media coverage

EXPLAINER

Maternity staffing levels double at scandal-hit Shrewsbury and Telford NHS Trust in last year

CENTRAL | SHROPSHIRE | TELFORD | OCKENDEN REPORT | Monday 6 February 2023 at 5:40pm

itv NEWS Central

BBC NEWS

'Progress but more to do' - Shrewsbury and Telford Hospital trust

6 February

Maternity services Facebook page launched

Shropshire maternity scandal: Hospitals boss satisfied with Ockenden Report progress

By Dominic Robertson | Telford | Health | Published: Feb 7, 2023

The boss of Shropshire's major hospitals says they are on track to meet the recommendations from a report into the country's biggest ever maternity scandal – but insists there is no complacency as they look to make lasting change.

Shropshire STAR

Proactive, Not Reactive

The Shrewsbury and Telford Hospital NHS Trust

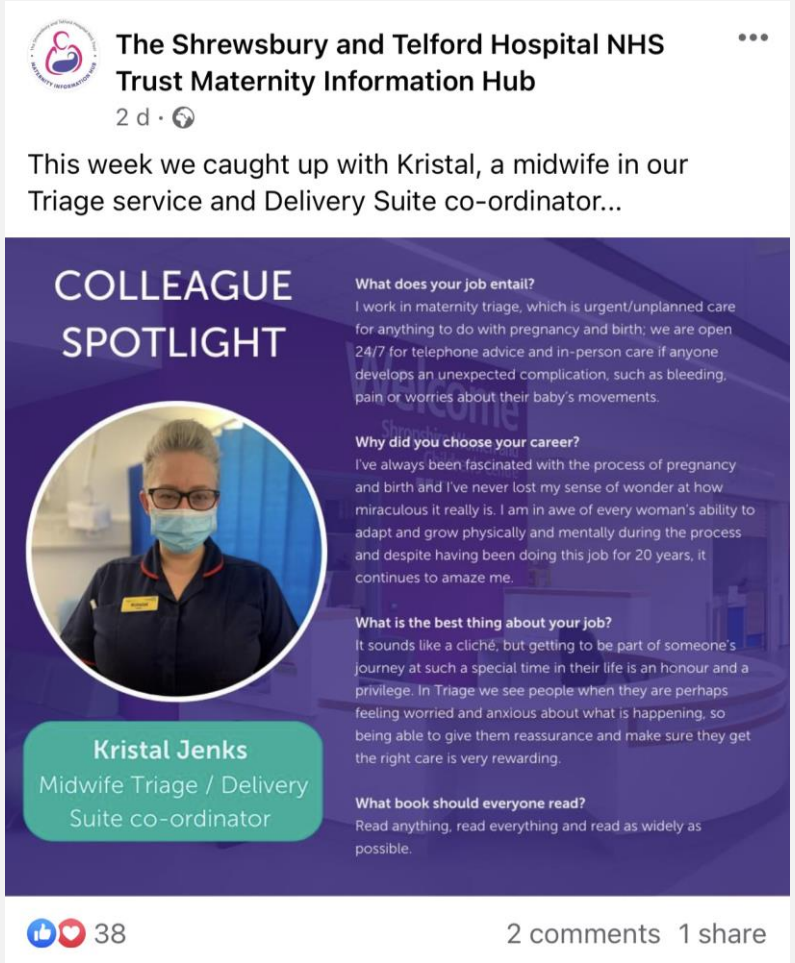
Ms. Hayley Flavell – Executive Director of Nursing, and Dr. Mei-See Hon – Clinical Director for Obstetrics, interviewed by Jim Hawkins, BBC Radio Shropshire. October 2022.

Ms. Hayley Flavell – Executive Director of Nursing, interviewed by Jim Hawkins, BBC Radio Shropshire. October 2022

Dr. Mei-See Hon – Clinical Director for Obstetrics, interviewed by Jim Hawkins, BBC Radio Shropshire. October 2022

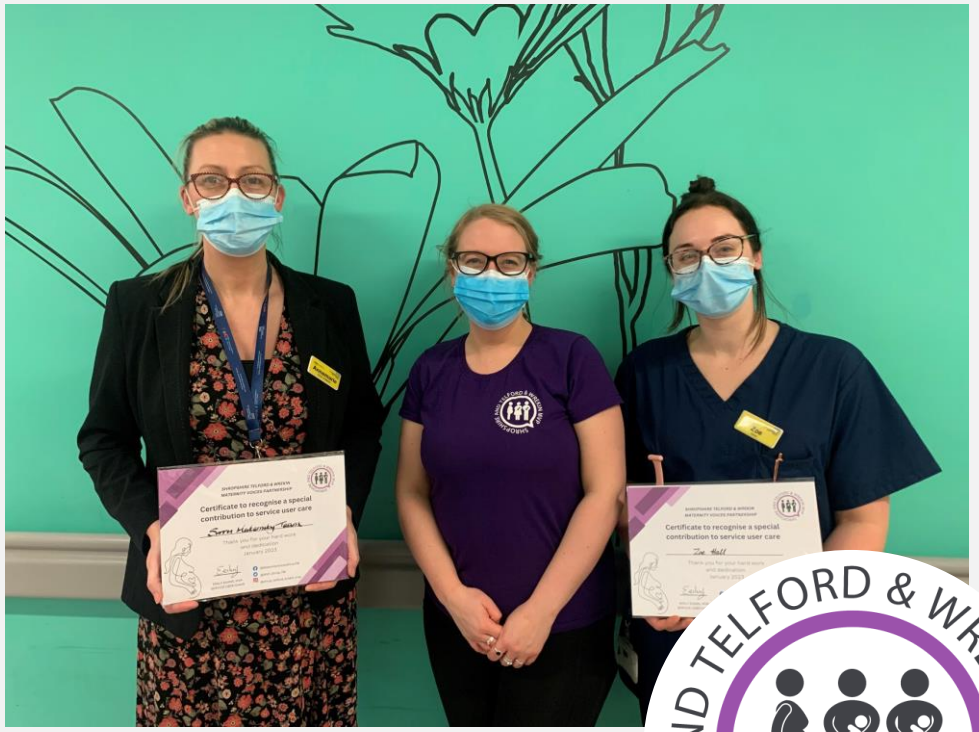
3. Engaging with Families and Colleagues

Facebook



- Our Maternity Service Facebook page was launched in October 2022
- The page offers health and pregnancy advice, innovations, improvements, staff achievements and patient experiences.
- The page also provides another opportunity for women and families to get in touch with feedback or questions, and allows us to respond to and signpost service users who contact the page.
- The page has more than 1,250 followers to date and we have reached more than 7,000 people in the last 28 days with more than 3,000 engagements

Maternity Voices Partnership (MVP)



Our work with the MVP is an important part of ensuring we are listening to women and families and placing them at the centre of everything that we do.

This work includes:

- ✓ User Experience (UX) Initiative
- ✓ Capturing feedback, which we then act on and incorporate into our work
- ✓ Participation, engagement and co-production on projects, such as the website redevelopment
- ✓ Inviting for quotes in press releases and media activity

4. Regular Updates on Improvement Work

Sharing Improvements More Widely

The Shrewsbury and Telford Hospital NHS Trust

- Sharing the MTP improvement work with our audiences is key to met our vision for the communications plan. Being open, honest and transparent is central to our approach.
- To do this, we use all our communications channels to reach the largest possible audience.
- Key channels (internal and external):

  - ORAC videos (livestream)
  - Cascade (briefings)
  - IMPACT (magazine)
  - Collaborate - the Integrated Care Board (ICB) newsletter
  - Members of Parliament and leader briefings via the ICB
  - Other (website, Facebook, Twitter, MVP, email bulletins, and more)

Next Steps

Next Steps

- Stakeholder communications
- Reflection on one-year post-Ockenden publication
- BBC Radio Shropshire tour and interview
- Launch maternity section of the SaTH website
- Continue to develop and grow our social media channels
- Internal maternity services newsletter focusing on improvements that have taken place so far and summary of plan for next few months

Thank you. Any questions?