The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 October 2023

Agenda item		120/23		
Report Title		Ockenden Report Assurance Committee – Co-Chairs' Summary Highlight Report		
Executive Lead		Director of Governance		
Report Author		Keith Haynes, Independent Governance Consultant		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF4
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	970, 1083, 1930, 2027, 2065
Well Led	√	Our partners	√	
Consultation Communication		N/A		
Executive summary:		The twenty-third meeting of the Ockenden Report Assurance Committee was held on 26 September 2023 and was livestreamed in public. This brief report provides a summary of key points/issues that were discussed at the meeting and highlights any matters the Co-Chairs wish to draw specifically to the attention of the Board of Directors.		
Recommendations for the Board:		The Board is asked to: • Note and take assurance from the contents of the report.		
Appendices:		None.		

Ockenden Report Assurance Committee

26 September 2023

Co-Chairs' Summary Highlight Report

1. The twenty-third meeting of the Ockenden Report Assurance Committee was held on the 26 September 2023 and was livestreamed in public.

2. This brief report provides a summary of the key themes discussed and highlights any particular matters which the Co-Chairs feel should be drawn to the attention of the Board of Directors. Ms Maxine Mawhinney chaired the meeting on this occasion.

3. Following our agreed approach to review progress of the implementation of the Ockenden Reports actions, and to focus on a service improvement area arising out of the report actions, we heard from Ms Annemarie Lawrence (Director of Midwifery) on progress in implementing actions from the first and final Ockenden Reports. We also had a detailed presentation from Ms Jacqui Bolton (Midwifery Matron) about Community Midwifery Services, and heard from our Maternity and Neonatal Safety Champions about their roles (Dr John Jones, Medical Director, and Dr Tim Lytttle, Associate Non-Executive Director).

4. **Integrated Care Board Meeting Report (27 September 2023) on System-wide Mortality Metrics**

   At the beginning of the meeting, it was thought that it would be helpful to hear from Dr John Jones in relation to the Integrated Care Board's (ICB) report (for presentation at the ICB meeting on 27 September) dealing with System-wide mortality metrics and, in particular, mortality rates in children – neonatal, infant and children. Dr Jones informed the Committee that the report indicated that, for neonates, infants, and children, the Shropshire, Telford and Wrekin ICB is showing higher mortality rates than the national average - for the four-year period between 2019-2023, neonate (28 days) and infant (28 days- 1 year) mortality was above the national average whereas for children (1 year – 17 year) there was a below average mortality rate, though the 2022-23 childhood mortality was above the national average.

   Whilst the focus of ORAC is maternity and therefore neonates, Dr Jones stated that all child deaths are tragedies and that we always seek to understand what has happened. He highlighted the improvement work that was taking place in SaTH's neonatal services, including an invited review of the service, led by the Royal College of Physicians and supported by the Royal College of Paediatrics and Child Health. At a future meeting (currently scheduled for February 2024), the Committee is also committed to considering outcome measures including perinatal mortality data.

5. **Progress Update in implementing the actions from the Ockenden Reports**

Ms Lawrence confirmed that as of September 2023, of the total 210 Ockenden actions, 164 had been evidenced and assured, 21 delivered not yet evidenced, and 25 not yet delivered. This compared favourably with the projected delivery position (i.e. 113 evidenced and assured, 59 delivered not yet evidenced, and 38 not yet delivered).

Ms Lawrence went on to explain that the completion rates of the actions from the first Ockenden Report, 48/52 (92%) of actions had been implemented and of these 46 (88%) had been evidenced and assured, 2 (4%) were delivered and not yet evidenced, and 4 (8%) of the actions had not yet been delivered, with these actions being de-scoped as lying outside the Trust's control. From the final Ockenden Report, 137/158 (87%) of actions had been implemented and of these 118 (75%) had been evidenced and assured, 19 (12%) had been delivered and not yet evidenced, and 21 (13%) actions not yet delivered, with two-thirds of these underway for delivery.

We also heard about the "red" actions from the first and final reports (ie. actions which are not yet delivered) and their progress. From the first report for IEA 1.14, requiring that an LMNS (Local Maternity & Neonatal System) cannot function as a sole maternity service, this externally dependent action remains "off track". It was explained that this action is being led by the ICB and continues to be debated with the ICB at the MTAC meetings. While some progress has been made in developing a service level agreement with other LMNSs, the expected benefits realisation for this Trust from entering such an arrangement remains, as yet, unclear. The ICB is progressing this further and it will remain a matter arising at MTAC. From the final report of the 21 "red" actions not yet delivered it was explained that 9 of these are "de-scoped" and the remaining 12 are on track for delivery.

In response to the on-going need to ensure that green actions remain green and the actions/improvements continue to be sustained, Ms Lawrence explained the role of the Maternity Transformation Assurance Tool in supporting this process. In particular, a series of audits are planned to ensure sustainability of actions/improvements, the outcomes of which will be reported quarterly to the Maternity Transformation Assurance Committee.

6. **Community Maternity Services and the Role of our Maternity & Neonatal Safety Champions**

Ms Jacqui Bolton, Midwifery Matron, gave a detailed presentation about Community Maternity Services. She explained the full range of services available in the community setting, whilst also highlighting the geographical spread of the services across the county, which bordered five other counties. Ms Bolton also confirmed the completion of all of the Ockenden report actions relating to community maternity services and highlighted some of the service improvements that have been made as a consequence, including the introduction of the birth preferences card which starts in

the community, the extension of safety champions walkabouts to the community setting, etc.

We also heard from our Maternity & Neonatal Safety Champions, with each describing the role and its importance. They explained that there were monthly safety champion meetings in place, co-chaired by the Executive Director and Non-Executive Director leads, with a schedule of bi-monthly visits in place. There is a “you said, we did” feedback system in place to demonstrate areas of improvement and progress. The process also supported with the involvement of Maternity Voices Partnership.

7. **Discussion and Reflection**

In discussion, it was felt that the following items and points of discussion should be drawn specifically to the attention of the Trust Board:

- It was acknowledged that when the Committee started its work in 2021, there was a significant amount of external participation in the meetings, including public participation. This is now falling off, and so there is a need to ensure that we remain extra vigilant in our challenge of the information shared.

- It continues to be a priority to re-establish the trust and confidence of our local communities in our services.

- We heard positive feedback about improved recruitment to maternity services and how midwives wished to come and work for the Trust.

- As ever, there was a recognition that service improvement is a continuous journey and there could be no room for complacency. It is encouraging to note, therefore, that the service has an approach to ensure the sustainability of the changes/improvements that have been made so far.

8. **Date and time of next meeting**

The next meeting is Tuesday 28 November 2023 at 2.30pm (livestreamed). In keeping with the intention to deal with the work of the Committee through the existing maternity service arrangements from 2024, the last meetings of the Committee will take place in February and April 2024 on dates to be confirmed.

Dr Catriona McMahon and Ms Maxine Mawhinney
Co-Chairs, Ockenden Report Assurance Committee
29 September 2023