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The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		152/23		
Report Title		Ockenden Report Assurance Committee 28 November 2023 – 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-fourth meeting of the Ockenden Report Assurance Committee was held on 28 Novembeer 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

28 November 2023

Co-Chairs' Summary Highlight Report

1. The twenty-fourth meeting of the Ockenden Report Assurance Committee was held on the 28 November 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 Carol McInnes (Divisional Director of Operations, Women's and Children's Services) and Ms Kim Williams (Head of Midwifery) on progress in implementing actions from the first and final Ockenden Reports. We also had a detailed presentation from Ms Williams about Learning from Incidents.

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

   Ms McInnes confirmed that as of November 2023, of the total 210 Ockenden actions 169 had been evidenced and assured, 22 delivered not yet evidenced and 19 not yet delivered. This compared favourably with the projected delivery position (i.e. 153 evidenced and assured, 45 delivered not yet evidenced and 12 not yet delivered).

   Ms McInnes went on to explain that the completion rates of the actions from the first Ockenden Report were 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, 143/158 (91%) of actions had been implemented and of these 123 (78%) had been evidenced and assured, 20 (13%) had been delivered and not yet evidenced, and 15 (9%) of actions not yet delivered, with two-thirds of these underway for delivery.

   The Committee also heard about the status changes for a range of actions following meetings of the Maternity Transformation Assurance Committee (MTAC) in October and November, and details of the de-scoped actions which continue to be reviewed by MTAC on a quarterly basis.

   There remain 41 (19%) of actions that are not yet evidenced and assured, which include 10 de-scoped (lying outside the scope of the Trust to directly deliver) actions. The Committee heard that work is underway to deliver the remaining actions before the March 2024 completion date. However, eight of these actions require additional

recurrent funding, which are the subject of a funding business case which has been developed and is supported by the Executive Management Team. There is also some ring-fenced national funding that will contribute to the funding of the business case. The actions which require additional recurrent funding are actions from the final Ockenden Report, namely IEAs 4.3, 8.1, 11.1, and LAFLs 14.32, 14.52, 14.57, 14.59 and 14.8. Needless to say, the Committee is supportive of the business case for additional recurrent funding.

5. **Learning from Patient Safety Incidents**

We heard from Ms Kim Williams (Head of Midwifery) about the processes and arrangements that are in place for dealing with patient safety incidents, and the importance of ensuring that the learning from them is captured and used to improve services. In relation to the process for handling patient safety incidents, depending on the initial categorisation of the incident, if no or low harm has resulted it will be dealt with at ward level but all other incidents (categorised as being moderate, severe or resulting in death) are dealt with at divisional level (Divisional Oversight Assurance Group) and/or Trust level (Review Actions Learning from Incidents Group). Some incidents (that meet the criteria for referral) are also subject to external review and investigation by the new Maternity and Newborn Safety Investigations programme (replacing former Health Services Safety Investigations Body).

In terms of incident trends and themes, the Committee heard that the top incidents for maternity services related to staffing levels, and for neonatal services, term admissions. 60% of reported incidents are assessed as resulting in no harm, although the learning is always reported and shared; 38% are assessed as low harm, 2% as moderate and less than 0.1% as severe or resulting in death.

The Committee heard a specific example of a patient safety incident where a woman had not been appropriately triaged in accordance with the Birmingham Symptom Specific Obstetrics Triage System (BSOTS) and where, following review of the incident, specific training in triage and use of the tool had been put in place for midwives.

The Committee was reminded that a number of the Ockenden report actions related to patient safety incidents and that the actions had been implemented and were being audited to ensure that they remained ‘evidenced and assured’. Finally, as we know, the incident investigation reporting system is due to be replaced shortly with the Patient Safety Incident Response Framework (PSIRF).

6. **Discussion and Reflection**

Mindful that the final two meetings of the Committee will take place in February and April 2024, the Co-Chairs have asked that at its next meeting the Committee is provided with an outline of the governance arrangements and pathway for dealing with the Ockenden report actions when the Committee ceases its work.

As a reminder, the final two meetings of the Committee are scheduled to deal with the following items:

27 February 2024

- How do we know our maternity services are safe (outcome measures)
- +/- Latest CQC Survey/Inspection (if available)
- Rolling programme of audit – sustainability + process/arrangements for providing ongoing assurance when ORAC ceases.

30 April 2024 – Final ORAC meeting

- Round up of the overall learning from the Independent Maternity Review
- +/- Latest CQC Survey/Inspection (if available)
- Celebration of successes
- Work still to do – transition to existing assurance arrangements.

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

The next meeting is Tuesday 27 February 2024 at 2.30pm (livestreamed).

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