The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 March 2024

Agenda item		041/24		
Report Title		Ockenden Report Assurance Committee 27 February 2024 – Co-Chairs' Summary Highlight Report		
Executive Lead		Director of Governance		
Report Author		Mike Wright, Programme Director – Maternity Assurance		
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-fifth meeting of the Ockenden Report Assurance Committee was held on 27 February 2024, 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: • Receive this report for informaiton and assurance.		
Appendices:		Presentation Slides from ORAC – 27 February 2024 available via the following hyperlink: Microsoft PowerPoint - ORAC Feb-24 DRAFT v2 (sath.nhs.uk)		

Ockenden Report Assurance Committee

27 February 2024

Co-Chairs' Summary Highlight Report

1. The twenty-fifth meeting of the Ockenden Report Assurance Committee was held on 27 February 2024 and was livestreamed in public.

2. This report provides a summary of the key themes discussed, and highlights any particular matters that the Chair feels should be drawn to the attention of the Board of Directors. Dr Catriona McMahon chaired the meeting on this occasion. The full presentation slides from the meeting are available via the hyperlink on the cover page.

3. Ms Kim Williams, Head of Midwifery presented the first section of the meeting, which focused on the recent results of the Care Quality Commission's Maternity Survey 2023, the implementation of actions from the two Ockenden Reports, the work that is underway to ensure that delivered actions are sustained, and the proposals for the future governance and assurance of the same. For the second half of the meeting, Dr Mei-See Hon, Clinical Director – Obstetrics, and Mrs Annemarie Lawrence, Director of Midwifery, led a presentation and discussion entitled, "How do we know our services are safe?"

4. **<u>Progress Update in implementing the actions from the Ockenden Reports</u>**

5. Ms Williams confirmed that the national results from the Care Quality Commission's Maternity Survey 2023 had been released. Further details of the Trust's results, when compared to other maternity providers in England, are described in this month's Integrated Maternity Report to the Board. These latest results present an overall positive picture, but with some areas still requiring focused attention from the Trust and its system partners. Areas of positive performance included antenatal care, communication with women relating to the induction of labour, women feeling involved in decisions relating to their care, and them being treated with kindness and compassion. Areas that require further improvement are in the areas of infant feeding, and the mental health and wellbeing of women during both antenatal and postnatal periods. The service will continue to work to address these matters.

6. As of 13 February 2024, of the total 210 Ockenden actions, 175 had been 'evidenced and assured', 17 'delivered, not yet evidenced' and 19 'not yet delivered'. Overall, this compared favourably with the projected delivery position at this time (i.e. 170 'evidenced and assured', 36 'delivered not yet evidenced', and 4 'not yet delivered').

7. Ms Williams presented that, of the 35 actions yet to be fully delivered and evidenced and assured, 10 were 'on track' to meet their projected deadline. Of the remaining 25 actions, four were 'off track' and concern the Trust being a Single Local Maternity and Neonatal System (LMNS), the Implementation of the Independent Senior Advocate role [two actions], and the Trust's current limitations, for logistical reasons, from being unable to release senior medical and advanced neonatal nurse practitioners to gain experience in other units. The Integrated Care Board is the lead agency for the first three of these actions, and the fourth remains within the gift of the Trust to deliver as soon as is reasonably practicable. Of the remaining 21 actions, 12 are currently/potentially at risk, 11 of which are pending securing permanent funding for them to be able to be

implemented fully. These are the subject of a business case, currently. The remaining 9 actions are de-scoped, as they are dependent upon external agencies to deliver them. All of the outstanding actions remain under review by the Maternity Transformation Assurance Committee (MTAC), which meets monthly.

8. **Ensuring ongoing action delivery and compliance**

9. Ms Williams presented the work that is underway to ensure actions that have been delivered fully are remaining in that position, or whether they need further attention. The service is finalising the Maternity Transformation Assurance Tool (MTAT), which is a bespoke audit tool to check on the continued delivery of the Ockenden Reports' actions. MTAT will form part of the maternity forward audit plan. Within this, provision will exist to enable actions that are not being sustained (Green), to revert to either delivered not yet evidenced' (Amber), or 'not yet delivered' (Red). Should an action's performance deteriorate, it will be re-addressed through the maternity governance and assurance systems and processes.

10. Ms Williams then discussed the work that is underway currently within the women and children's division, to review the maternity governance and assurance systems that will be in place once the Ockenden Report Assurance Committee finishes its work in April 2024. Whilst this is work in progress, it is considering what the future scope of the maternity transformation programme will look like, including the ongoing management of the actions from the Ockenden reports. Matters under consideration include how the executive directors will retain oversight, how external partners will be involved, and what levels of independent assurance will be required. The proposed model/options will be discussed at the April MTAC meeting, but will be presented to the Board of Directors for final decision, in due course.

11. **How do we know our services are safe?**

12. Dr Hon and Mrs Lawrence then presented the thematic section of the meeting, which was entitled, "How do we know our services are safe?".

13. The presentation considered the advice provided by Dr Bill Kirkup CBE, chair of the review of maternity and neonatal services at East Kent Hospitals NHS Trust. In his report, 'Reading the Signals (2022)', Dr Kirkup advised that, while there is a dearth of useful information on the outcome of maternity services, a large majority are process measures of dubious significance, such as caesarean section rates, perinatal mortality rates and unit league tables. Dr Kirkup states that such measures can conceal events that are susceptible to clinical intervention, and do not often explain whether a unit's performance is due to them being an actual outlier or just by chance. The reason for this is because is there are no simple metrics to demonstrate quality or good outcomes in themselves. With this in mind, the presentation from Dr Hon and Mrs Lawrence considered how can they state with a high degree of confidence that services are safe today?

14. Dr Hon described the components of a safe and effective service, which comprised: strong and sustainable leadership, oversight, and assurance processes, up to date practices and techniques, the right culture, listening to the voices of women and families, effective workforce planning and levels, delivery of national initiatives and effective risk management.

15. Dr Hon and Mrs Lawrence then described what is different now compared to the past, under the themes of leadership, workforce, clinical practice, quality and safety, assurance, and culture. Examples were provided, including how the service had created stability in the local leadership team and how they had undertaken leadership development as a team. New senior roles have been added, for example, the Head of Midwifery, a Consultant Midwife, and more matrons. The maternity workforce has improved not only in numbers of both medical and midwifery colleagues, but also in relation to the supportive development programmes that are now in place. Examples included the midwifery degree apprenticeship programme and the labour ward coordinator development programme. Further assurance was provided that there are currently no midwifery vacancies at the Trust. Consultant obstetricians now have dedicated time incorporated in their job plans to undertake training and work relating to quality roles and service improvement. Also, the Trust has secured 24/7 consultant obstetrician presence to provide direct care and advice, and to ensure escalation routes to the most senior doctors are always available to staff.

16. With regards to the topic of up to date clinical practice, Mrs Lawrence advised that all maternity guidelines are now current, up to date, and have been benchmarked against national guidance. Also, as the Board of Directors has been apprised already, the Trust has delivered all ten of the safety action requirements of the Clinical Negligence Scheme for Trusts – Maternity Incentive Scheme (Year 5), and the Saving Babies Lives Care Bundles (versions one and two), with good progress being made on version three of this bundle.

17. Dr Hon and Mrs Lawrence described many other improvements, including a new escalation policy and conflict of clinical opinions policy, an enhanced mandatory training policy and programme, strengthened risk assessment processes at every contact with each woman, improved co-production with women relating to their individualised care, improved relationships with the maternity and neonatal voices partnership, and the introduction of a birth reflections service.

18. Notwithstanding the advice of Dr Kirkup mentioned previously, the service still reviews the maternity dashboard, which is updated daily and comprises over fifty metrics, and helps the clinical teams to identify any further areas for scrutiny or attention. In addition, the service uses information obtained from the 'Badgernet' electronic patient record, which has been in place for two years now, to help identify performance trends and other useful data. The service is also part of the DExTER (Data Extraction for Epidemiological Research) exercise, which is a system designed to uncover insightful trends and patterns, and to automate time consuming audits. This will enable the service to make data driven informed decisions, to help improve service provision.

19. Dr Hon and Mrs Lawrence advised that the service has made improvements to the ways in which patient safety incidents are reported, escalated, scrutinised, and managed, both within and external to the division. This includes escalation to executive directors, as necessary. Furthermore, improvements have been made to ensure that statutory duty of candour requirements are met.

20. Other improvements were described, including better project management, and governance and assurance systems and processes for managing any required actions. This includes improved oversight from systems partners, including the Integrated Care Board, Healthwatch, The Local Maternity and Neonatal Services, NHS England, and the Maternity Voices Partnership. The cultural improvement work continues also, with

particular focus on improving communications with staff, debriefing sessions, and greater support for colleagues' health and wellbeing.

21. In summary, good progress is being made in many areas but the service also recognises that there is still more to do to continue to improve further. This work continues.

22. **Discussion and Reflection**

23. Members of the committee congratulated the service and recognised the improvements and progress made to date.

24. The committee requested of the Board of Directors to be mindful of the need for recurrent funding in order to be able to deliver and sustain 11 of the outstanding actions.

25. Progress is being made in determining the ongoing governance and assurance arrangements for all maternity improvement work, including the actions from the Ockenden Reports, and especially when ORAC has concluded its work. However, these will need to be finalised and agreed by the executive team and Board of Directors.

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

The final ORAC meeting will be on 30 April 2024, and will comprise:

- A round up of the overall learning from the Independent Maternity Review
- +/- Latest CQC Inspection Report (if available)
- Celebration of successes
- Work still to do – the transition to revised governance and assurance arrangements.

Dr Catriona McMahon
Co-Chair, Ockenden Report Assurance Committee
5 March 2024