The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 9 May 2024

Agenda item		071/24		
Report Title		Ockenden Report Assurance Committee 30 April 2024 – Co-Chairs' Summary Highlight Report		
Executive Lead		Director of Governance & Communications		
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-sixth and final meeting of the Ockenden Report Assurance Committee was held on 30 April 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 – 30 April 2024 available via the following hyperlink: PowerPoint Presentation (sath.nhs.uk)		

Ockenden Report Assurance Committee

30 April 2024

Co-Chairs' Summary Highlight Report

1. After running for three years, since March 2021, the twenty-sixth and final meeting of the Ockenden Report Assurance Committee was held on 30 April 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. Mrs Maxine Mawhinney chaired the meeting on this occasion. The full presentation slides from the meeting are available via the hyperlink on the cover page.

3. The senior leadership team for maternity services presented the background to the Independent Maternity Review, along with a summary of the progress and changes made, and the impact these are having on service users and colleagues. The presentation highlighted ongoing challenges, and the actions that are being taken to deliver outstanding actions. The committee also learned what the ongoing governance and assurance systems and processes will look like going forward and feedback was sought from committee members on the work of ORAC and the maternity, neonatal and anaesthetic teams.

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

5. Dr Mei-See Hon, Clinical Director for Obstetrics, opened with a reminder of the background to and findings of the Independent Maternity Review, which was chaired by Donna Ockenden. Dr Hon described that the Maternity Transformation programme became operational in November 2020, and spoke to a summary timeline of key events since November 2020, when the Maternity Transformation Programme in its current format was developed. Dr Hon explained a background to the inception of ORAC, just over three years ago, also.

6. Dr Hon presented that, as of 9 April 2024, of the total 210 Ockenden actions, 178 had been 'evidenced and assured', 14 'delivered, not yet evidenced' and 18 'not yet delivered'. This is the first month that the delivery of actions is below the planned trajectory. Mrs Annemarie Lawrence, Director of Midwifery explained that, of the 32 actions that are yet to be delivered, the breakdown is as follows:

On track	10
Currently off track	0
At Risk – not related to business case	1
At Risk – pending business case approval	11
De-Scoped	10

7. Mrs Lawrence described the on-track actions, explained some as examples, and that each have agreed dates for obtaining 'amber' and then 'green' (full) compliance.

8. Mrs Lawrence explained that the 'at risk' action that is not linked to the business case relates to IEA 1.7 from the final report. This action requires all midwives coordinating the labour ward to attend a nationally recognised education module. The Trust's labour ward coordinators have undertaken a locally devised programme. As no national programme existed, the Trust's programme has now been adopted as the basis for the development of the national programme, which is underway. Therefore, any risks to final delivery of this action are minimal. Logistically, it will take time to progress all coordinators through the new national programme; therefore, it will remain 'at risk' in the meantime.

9. With regards to those actions pending business case approval, Mrs Lawrence explained that this continues to be the subject of an ongoing discussion and assessment with the Integrated Care Board and NHS England, and includes reviewing the quality and equality impact assessments associated with these actions. Where possible, some mitigating actions are being taken by the Trust in the meantime to reduce the risks, but these will be mostly time limited without the substantive funding.

10. Ten actions remain de-scoped currently, and relate to actions that are being led externally to the Trust. These continue to be monitored through the Maternity Transformation Assurance Committee.

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

12. Mrs Lawrence presented the Maternity Transformation Assurance Tool (MTAT), which will form a part of the maternity forward audit plan. MTAT will review periodically all actions that have been delivered fully and previously, to ensure they are being sustained. It was reassuring to learn that the option remains for actions to revert back to 'Not Yet Delivered' or 'Delivered, Not Yet Evidenced,' where sustainability evidence is no longer present.

13. Mrs Lawrence explained what the revised governance and assurance arrangements to verse all of this will look like going forward.

14. **Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme (MIS) update**

15. Mrs Lawrence advised the committee that, further to the Board of Directors confirming compliance with all ten safety actions for the CNST Maternity Incentive Scheme – year 5 at the end of January 2024, the Trust has received confirmation from NHS Resolution that all actions have been externally verified and confirmed as being met. Also, Mrs Lawrence described that the Trust had delivered on all elements of the Saving Babies Lives Care Bundle version three.

16. The guidance for year six of the CNST MIS scheme was issued recently and is being worked through currently.

17. **Improvements made by implementing the Ockenden actions**

18. Mrs Lawrence gave examples of some of the many improvements that have been made by delivering the actions from the Independent Maternity Review. These included improvements to multidisciplinary team working and training, enhanced clinical governance arrangements, consultant led ward rounds and 24/7 presence, improved bereavement support arrangements, better information for service users, psychology support for staff, and the on-going cultural improvement work. Improvement in neonatal services included an increase in 'qualified in speciality' neonatal nurses to meet British Association of Perinatal Medicine (BAPM) standards.

19. Mrs Lawrence described the support maternity services received from the chief executive, director of nursing, medical director, and non-executive directors. She explained how accessible, visible, and approachable the executive directors were, that they understood the challenges faced by the service and cared about women, families, and staff, and how much this was appreciated.

20. Mrs Lawrence then discussed the improvements the service has made and continues to make in relation to community engagement. Examples given included the co-production of the Birth Preferences Card with women, families and the Maternity Voices Partnership, and the open days the service now held to help support women and families.

21. The presentation included videos from staff that described the improvements as they saw them. These included: improvements to multidisciplinary teaching, training and team working, improvements that are clinically led and developed, the 'manager of the day' initiative, the positive impact of the consultant midwife role, 24/7 consultant presence (especially at night), the approachability of the senior medical staff, regular multidisciplinary ward rounds, equipment and technology improvements such as more modern Cardiotocograph (CTG) machines, improved telemetry facilities, drop in sessions for staff to meet with senior leaders, and the positive impact internationally recruited colleagues were having within the service. This section of the presentation included a video from a service user named Amy. Amy spoke about how she had a really positive relationship with her community midwife, and that it was really beneficial for her to have the same person throughout her antenatal care.

22. **Maternity Transformation Programme (MTP) - Phase Two**

23. Mrs Carol McInnes, Operations Director for the Women and Children's Division, described the changes that are being made as part of refreshing and updating the MTP workstreams. Fundamentally, the principles will remain the same and will include ensuring that the actions from the Independent Maternity Review are sustained, alongside the need to meet the requirements of national initiatives, external visits, and regulatory requirements.

24. With regards to the governance and assurance structure within which this will all be managed, again this remains largely the same. The Maternity Transformation Assurance Committee, chaired by the executive director of nursing, will continue to govern the MTP, which will in turn report to the Quality and Safety Assurance Committee and on to the Board of Directors.

25. **What Drives our Service?**

26. In summing up the presentation, and in terms of what drives the team to learn and improve further, Dr Hon presented a testimony and video from a service user named Kara. Kara thanked the team following the birth of her baby boy. Kara's words were so poignant that these are included verbatim below (permission has been obtained):

"In 2020 I had a traumatic birth with my son. This left me distrusting unconfident that I could ever deliver a baby safely. When I arrived at hospital to have my second baby, I was greeted by the lovely midwife, Becky G. She put on projector lights and had music playing ready for our arrival which put me at ease right away. The room we were put into was gorgeous, cosy, and relaxing! Becks was so warm and welcoming, and I knew I was in safe hands which meant a lot to me. Unfortunately for everyone there with me, I get very loud on gas and air, but Becky reassured me through the whole 4 hours of labour and encouraged me when I doubted myself. My mental health birth plan was read and completely respected. I felt so safe and listened to. Becky is an amazing midwife with so much empathy and compassion. At what felt like such a vulnerable time for me, she empowered me and restored my confidence and trust in myself. She is someone I will forever be grateful for, and I will never forget. I am sure she will also never forget me and the things that came out my mouth that night! We would also like to thank the medical student, Kieran C, who was present during the entire labour & birth. You were 'on it' to find me a birthing ball and you stayed through all my shouting! Thank you too, to the lovely Alicia H. also who was present for the birth and popped the waters as our boy was born in the sac! She was amazing. The aftercare we received was great and my wishes to be kept with my birthing partners afterwards due to my complex post-traumatic stress disorder was completely respected and we were kept in our birthing suite until I was discharged. I was taken care of and discharged by Victoria P who is just lovely and was there whenever I needed anything. The entire birth was a healing experience I did not realise I needed so badly until it happened. Thank you all for supporting, healing, and empowering me. We will forever be grateful. From Kara, Aaron & baby Luca."

27. **The Journey Continues**

28. Dr Hon concluded the presentation by acknowledging that the service had come a long way, with a great deal of work and that, whilst some actions remained to be delivered, they were proud of all the teams that have contributed the improvement work. Dr Hon thanked key individuals that have bene part of this, by name.

29. In closing, Dr Hon acknowledged that there is: "*always more to do; always more to learn*."

30. **Discussion and reflections**

31. A rich discussion followed, whereby committee members gave their thoughts and feedback.

32. Mrs Hayley Flavell mentioned that this had been quite a journey, and the situation was vastly different now form when it all started. That today was a brilliant celebration demonstrating real improvement but with still work to go. Hayley mentioned how incredibly proud of what the team has achieved.

33. Mrs Sarah Dunnett Non-Execuitve Director and Maternity Safety Champion, advised that she had witnessed a really good overview of governance. Mrs Dunnett was keen to advise that the governance going forward should focus on key important areas such as service user experience, culture and how staff are feeling. Mrs Dunnett felt that the right things were in place and that this is an organisation that its maternity oversight really well developed and, perhaps, leading the way in some elements. Mrs Dunnett felt confident that event though ORAC was stopping, it will not mean this work is lost or forgotten. She felt the service was safe and that she was looking forward to the publication of the CQC inspection report that would hopefully reflect the positive work. In response to a question from Dr McMahon, Mrs Dunnett advised that one of her areas of focus as safety champion would be to ensure that staffing levels were safe, as so much depended upon them being correct and safe.

34. Mrs Rosi Edwards, Non-Executive Director and chair of the Quality and Safety Assurance Committee (QSAC) described that she would be keen to ensure that the maternity safety champions were not overloaded, and that MTAC and QSAC should oversee most of this work, whilst remaining relevant. Mrs Edwards explained QSAC saw already several papers pertaining to maternity matters, and mentioned that it was crucial for MTAC to continue its work.

35. In response to a question form Dr McMahon regarding external scrutiny of the Trust's plans and progress, Mrs Edwards explained that QSAC included ICB representation and that she was also on the ICB's Quality Committee. As such, she considered this to be sufficient but that all committees needed to be open about the work they do, and that external oversight remained important. Dr McMahon asked Mrs Edwards what was going to be on the 'watch list' for QSAC? Mrs Edwards advised that neonates, equality issues that lead to poor outcomes and maintaining the work with women and families were key.

36. Mr Richard Kennedy, Consultant Obstetrician and Gynaecologist from Birmingham (and original ORAC member as Deputy Medical Director for NHSE Midlands) suggested that effective and capable maternity leadership, strong governance framework and great exec support was a recipe for success. He cited that, as Dr Hon had advised, it is a journey and transitioning to business as usual was key. Dr Kennedy said that "your service is an exemplar to others." Dr Kennedy also commented that it was good to see the change in the dashboard and the 'greens' dominating. He declared this was a recipe for success and suggested the Trust was an exemplar to others.

37. Mr Kennedy advised that his lingering concerns were about neonatal services and a higher than average neonatal death rate. He described his lingering concerns were that this has been the 'Achilles heel' of the service for some time. He advised that it was good to hear about staffing improvements in neonates but said he would like to see that manifesting in improved neonatal outcomes. Dr Jones responded to this, advising that neonatal services remains a key area of focus and work for the Trust.

38. Mr Kennedy asked if the clinical team was healing as well as learning, and that the need for such healing was significant for teams that had been through immense scrutiny and adverse publicity? Dr McMahon thanked him for that question and asked if he had any examples of where this had taken place in other trusts. Mr Kennedy reflected form his own experience and said that the best way to manage this was to bring about improvements in care, safety and team working in order to get good outcomes which, in turn, resulted in happier patient and staff and where e attention then moves elsewhere.

39. Dr Jones then provided his further feedback and thoughts. He reflected that the maternity services improvements would be where they are without the support of his executive and divisional colleagues. He had witnessed good relationships between midwives and obstetrician, something that was not necessarily the same in other trusts, and identified that multidisciplinary team working was really positive. Dr Jones emphasised that where team working was positive, this would likely reduce the incidence of things going wrong. Dr Jones cited other examples of improvements including those around more regular risk assessments of pregnant women, the 'fresh eyes' approach, especially relating to CTG monitoring. Also, Dr Jones advised that, whilst improvements had been made with regards to openness and transparency, there was still more to do in this area.

40. Mr Simon Mehigan, Maternity Improvement Advisor for NHS England mentioned he had worked with the Trust for the past three years. Whilst it had been challenging at times, and the Trust had faced a level of scrutiny seldom seen by others, Mr Mehigan mentioned he had seen significant changes in processes that will be sustained even if key individuals are not there. He then mentioned he would be willing for his family member to have a baby at the Trust and, also would willingly work for the Trust himself.

    Mr Mehigan said he experienced real joy to see the Trust get to where it is now and that he would be sad to be stepping away for this soon. Mr Mehigan offered his congratulations to the team and felt confident the improvements would be sustained.

41. Ms Vanessa Whatley, Chief Nurse for NHS Shropshire, Telford, and Wrekin Integrated Care Board described she had seen so many improvements and that the service was a role model for others. Ms Whatley advised she had confidence in the Trust's maternity services, especially around the quality of care provided and risk management arrangements. Ms Whatley said the ICB was working closely with maternity and neonatal services at both service and executive levels and mentioned the ICB's critical role in maintaining oversight of them. Ms Whatley thanked the Trust for its response to the Ockenden reports and other challenges. She also advised it was essential that positive working relationships with the Local Maternity and Neonatal System (LMNS) and Perinatal Quality Surveillance were maintained.

42. In response to a question from Mrs Mawhinney relating to the ongoing funding required for some of the remaining Ockenden actions, Ms Whatley advised that she was working closely with the Trust on this, and it was an ongoing matter. She advised the need to balance limited fiscal resources with the priority needs of health services overall. This included understanding what possible mitigation was in place to help manage any risks. Ms Whatley described that it was a long and complicated business, but that they had to ensure services were safe.

43. For her closing comments, Mrs Louise Barnett, Chief Executive, mentioned she was extremely proud of the teams and the improvements made. She was incredibly grateful to women and families for their feedback and advised that it was essential to continue to listen to, and hear, what they were saying, so that the Trust could continue to learn and improve. Mrs Barnett thanked all external partners for their independent help, challenge, and input.

44. Mrs Barnett reflected on the phrase at the end of the presentation: "Always more to do; always more to learn," and felt that this sentiment was very pertinent. She felt assured

that there was acknowledgement that this improvement work is never finished, but is more of a continuous process.

45. Mrs Barnett advised that it was important to remember the services that work closely with maternity, such as anaesthetics and neonates, and that everyone need to be mindful that those serviced had some of their own challenges to address going forwards, also.

46. Mrs Barnett advised that, whilst the Trust worked with other trusts is different ways, it would be good to resolve the single LMNS matter, and that this remained to be resolved.

47. **Closing remarks**

48. In her closing remarks as co-chair, Mrs Mawhinney reflected on her time working with the Trust. She described her first impressions on taking up the post and visiting the Trust, meeting the teams, and seeing the services for herself. She described that, as a journalist it was the bad news that made the news, but that it was important for her to get behind this and see things for herself.

49. Mrs Mawhinney recalled that this had made her realise how difficult it was for hospitals in a difficult position to recover in the court of public opinion. However, she has been able to experience first-hand the enormous amount of work required, and that has taken place, to get the improvements we see today. Mrs Mawhinney recalled seeing a video of multidisciplinary working and how impressed she had been with this.

50. Mrs Mawhinney described how impressed she had been with the passion and enthusiasm and the sense of wanting to get things right but that it was regrettable that the public did not see this. She recalled some of the more significant changes such as 24/7 consultant cover, and remained hugely impressed, especially as she could see the confidence of women returning.

51. Mrs Mawhinney said this had been a real revelation for her, that the team worked so hard and that the work was not finished. However, she believed the team was fantastic! Mrs Mawhinney thanked those team members for their leadership and, also their support for her as co-chair.

52. The Maternity Transformation Assurance Committee will continue to report on Ockenden actions and overall maternity transformation matters to the Quality and Safety Assurance Committee. From this, the Board of Directors will continue to be apprised of progress and any other matters of relevance.

Dr Catriona McMahon
Co-Chair, Ockenden Report Assurance Committee
1 May 2024