Board of Directors Meeting - Cover Sheet

Subject:	Ockenden Final Report 30th March 2022	**Date:** 4th April 2022	
Prepared By:	Paula Shore, Divisional Head of Nursing and Midwifery Susanna Al-Samarrai, Service Director		
Approved By:	Julie Hogg, Chief Nurse		
Presented By:	Julie Hogg, Executive Board Safety Champion & Clare Ward, Non-executive Board safety champion		

Purpose		
To provide the board an overview into the recently published report into Maternity Services at Shrewsbury and Telford Hospitals, it's impact and actions required at Sherwood Forest Hospitals.	**Approval**	
	Assurance	**x**
	Update	**x**
	Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x	**X**	**X**	**x**	

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
Financial	
Patient Impact	**x**
Staff Impact	**X**
Services	**x**
Reputational	**x**

Committees/groups where this item has been presented before

None

Executive Summary

Following the publication of the interim report in December 2020, the final Ockenden report containing the findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust was published on 30th March 2022.

The first report outlined the Local Actions for Learning (LAfL) and Immediate and Essential Actions (IEAs) to be implemented at the Trust and across the wider maternity system in England.

This report builds upon the first in that all the LAfL and IEAs within that report remain important and must be progressed. A number of new themes have been identified with the creation of further Local Actions for Learning for the Trust and Immediate and Essential Actions, which must be implemented by The Shrewsbury and Telford Hospital NHS Trust with the IEAs considered by all Trusts across England in a timely manner.

Sherwood Forest Hospitals have declared full compliance to six out of the seven IEAs with the remanding requiring further working with newly appointed interim Chair of the Maternity Voice Partnerships to achieve full compliance. The new 15 IEAs are currently under review in preparation for the self-assessed return.

Overview

The review team examined the maternity care given to 1,486 families resulting in 1,592 clinical incidents, with the majority being over the time period 2000 to 2019.
In addition to the Trust's internal investigation and governance processes being reviewed, external reports into the Trust's maternity services over these years (national regulatory reports and locally commissioned reports) as well as ombudsman and coroner's reports have been scrutinised.

Alongside the 7 IEAs from the interim report that Trusts are providing assurance against, a further 60 local actions for SaTH have been identified. In addition, a further 15 IEAs have been developed for all organisations to implement, with particular attention being drawn to:

- Safe staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families

The final report has built on the concerns identified in the interim publication, based on reviews of the Trust's policies and procedures alongside interviews with both families and staff, past and present, to formulate its recommendations.

Themes of concern that run through the report are of an organisation that has failed:

'It failed to investigate, failed to learn and failed to improve and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives.'

Areas identified of concern were repeated patterns of poor care, resulting in the identification of significant or major gaps which, if care had been provided appropriately, could have changed the eventual outcome in relation to maternal and neonatal death, stillbirth and avoidable brain injury. This has been compounded by poor quality investigation processes alongside failures in governance and leadership at all levels. There was also criticism of a number of external reviews conducted by external agencies resulting in false reassurance about the Trust's maternity service despite repeated concerns being raised by families, highlighting a persistent failure to listen and believe.

In total more than 60 Local Actions for Learning have been identified specifically for the Trust in light of the care received by the 1,486 families featured in the review. There has been recognition within the report of recent improvement in maternity services at the Trust with increased numbers of senior clinicians employed following the publication of the interim report in December 2020 which should be acknowledged.

It is recognised that many of the issues highlighted in the report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years. This has resulted in the identification of 15 areas as Immediate and Essential Actions which should be considered by all trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.

Robust and funded maternity-wide workforce planning has been highlighted as essential to address the present and future requirements for midwives, obstetricians, anaesthetists, neonatal teams and associated staff working in and around maternity services. Without this,

maternity services cannot provide safe and effective care for women and babies. In addition, this workforce plan must also focus on significantly reducing the attrition of midwives and doctors since increases in workforce numbers are of limited use if those already within the maternity workforce continue to leave.

Particular reference is made to a specific action on continuity of carer: 'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place.

The immediate and essential areas for proposed national action from the report are:

Workforce planning and sustainability	Preterm birth
Safe staffing	Labour and birth
Escalation and accountability	Obstetric anaesthesia
Clinical governance (leadership)	Postnatal care
Clinical governance (investigation and complaints)	Bereavement care
Learning from maternal deaths	Neonatal care
Multidisciplinary training	Supporting families
Complex antenatal care	

Next steps

Trusts have been asked to set out at Public Board their organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. That position should have been discussed with their LMNS and ICS and reported to regional teams by 15 April 2022. A detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs will be published at NHSE/I public Board in May 2022.

The Sherwood Forest response has followed the timeframe and has gone to the LMNS prior to the region submission on the 15th of April.

Trusts will now be requested to self-assess their current position against the 15 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of effective implementation to their boards using a nationally developed assurance and assessment tool.

At Sherwood Forest Hospitals we have started the process of starting to self-assess using our previous governance frameworks for reporting.

Recommendation

That Board members note the contents of the report