Board of Directors Meeting - Cover Sheet

Subject:	Ockenden Final Report Update	**Date: 25/04/2022**	
Prepared By:	Paula Shore, Divisional Head of Nursing and Midwifery		
Approved By:	Robin Binks, Deputy Chief Nurse		
Presented By:	Julie Hogg, Executive Board Safety Champion & Clare Ward, Non-executive Board safety champion		
Purpose			
To provide the board with an overview of the recently published report into Maternity Services at Shrewsbury and Telford Hospital NHS Trust (SaTH) and its associated impact and actions required at Sherwood Forest Hospitals NHS Foundation Trust (SFHFT).		**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 15 Immediate and Essential Actions (IEAs) to be implemented at the Trust and wider maternity system in England. Within these 15 IEA's are 88 actions.

As a trust we 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, progress as outlined within this paper.

Overview

At Sherwood Forest Hospitals we have started the process of starting to self-assess using our previous governance frameworks for reporting through the Maternity Assurance Committee (MAC) whilst awaiting further national instructions around the reporting requirements.

The immediate and essential areas for proposed national action from the report are as outlined below and the evidence for the self-assessment review has commenced, to date we have had 6 IEA's peer assessed.

Ockenden Final Report 15 Immediate and Essential Actions	
1. Workforce planning and sustainability- completed	9. Preterm birth
2. Safe staffing- completed	10. Labour and birth
3. Escalation and accountability- completed	11. Obstetric anaesthesia
4. Clinical governance (leadership)	12. Postnatal care
5. Clinical governance (investigation and complaints)	13. Bereavement care
6. Learning from maternal deaths	14. Neonatal care
7. Multidisciplinary training	15. Supporting families
8. Complex antenatal care	

Next steps

The peer assessment will continue through the MAC with the aim to bring the final approved gap analysis and subsequent action plan to June's Board meeting.

Recommendation

That Board members note the contents of the report