The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
7 January 2021

Agenda item	008/21			
Report	The Ockenden Report			
Executive Lead	Chief Executive			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF1 BAF2 BAF8	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√	CRR16 CRR18 CRR19 CRR23 CRR27 CRR31	
	For noting			
	For information			
	For consent			
Presented to:	Directly to the Board of Directors			
Dependent upon (if applicable)**:**				
Executive summary:	This report provides an update on the following matters: • Receipt of The Ockenden Report (Dec 20) – Donna Ockenden's first report from the Independent Maternity Review (IMR) • Actions taken in response to receipt of the Ockenden Report The Board of Directors is requested to: • Receive and review the first Ockenden Report • Undertake a Board seminar session to reflect on whether the assurance mechanisms are effective and provide sufficient evidence of action and learning and report back to the next Board of Directors meeting in pubic. • Decide if any further information, action and/or assurance is required.			
Appendices	**Appendix One** - The Ockenden Report (2020) **Appendix Two** - Current position against the Local Actions for Learning and Immediate and Essential Actions (First Draft) **Appendix Three** - Maternity Improvement Work			

	Appendix Four - Assurance Statement **Appendix Five** - First Draft Maternity Services – Communication and Engagement Plan

1. PURPOSE OF THIS REPORT

This report provides information on the following matters:

- Receipt of The Ockenden Report (Dec 20) – Donna Ockenden's first report from the Independent Maternity Review (IMR)
- Actions taken in response to receipt of the Ockenden Report

2. THE OCKENDEN REPORT (IMR)

2.1. The Board of Directors is aware of the ongoing Independent Maternity Review that is chaired by Donna Ockenden.

2.2. On Thursday 10th December, Donna Ockenden released her first report from the Independent Review of Maternity Services at the Trust (**Appendix One refers**).[1] The report presents emerging findings and recommendations from 250 clinical reviews.

2.3. The report is a very harrowing and concerning read regarding significant failings in Maternity Care at the Trust between 2000 and 2018/19.

2.4. On behalf of the Trust, the Chief Executive has apologised unreservedly to the families involved and affected by this report, has committed that the Trust will learn from their experiences, and has accepted all of the report's findings and its recommendations.

2.5. This independent review happened only as a consequence of the diligence and determination of the families involved in continuing to seek answers to and accountability for the harm and suffering that they have endured and continue to endure. These are families that tried to raise concerns about the care and safety with the Trust's maternity and aftercare services but were not listened to and cared for as they should have been. This should never have needed to happen and it is contingent on the Trust to act on the report's findings without delay.

2.6. This first report includes:

2.6.1. Twenty-seven Local Actions for Learning (LAFL), which are specific 'Must Do' actions for this Trust, and;

2.6.2. Seven Immediate and Essential Actions (IEA) for all NHS providers of maternity care, which apply to this Trust, also. These seven themes comprise 25 related actions.

2.7. On receipt of the report, the Trust commenced work immediately to; assess progress against these actions, cross reference all of these required actions against the current work with the Maternity Improvement Plan (MIP) and Maternity Transformation Plan (MTP) and, pick up any new required actions that were not in place already. Whilst in its early stages still, progress is being made against the required actions. The Trust and the Women and Children's Care Group leadership team have embraced all of these requirements and will continue to focus and work hard with colleagues, women and their families and other stakeholders to address them. A fuller assessment of

[1] www.gov.uk/official-documents. (2010) Ockenden Report – Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our first Report following 250 Clinical Reviews.

the Trust's position against all of the 52 required LAFL and IEA actions is underway and will be presented to the Board of Directors at its next meeting in public. Meanwhile, the Trust's current position against the twenty-seven Local Actions for Learning and the seven Immediate and Essential Actions is provided at **Appendix Two**. Work to implement all actions continues at pace.

2.8. In addition to the actions in place to address the actions in the Ockenden Report, improvement work within maternity services was underway during 2020 and continues. A summary of this work is attached as **Appendix Three.**

2.9. A letter was sent to all NHS Trust and Foundation Trust Chief Executives on 14th December 2020 from NHS England and NHS Improvement in response to the publication of the Ockenden Report. The letter set out the requirement for all Trust Boards to receive the Ockenden Report at their next meeting in public.

2.10. Furthermore, the letter set out the requirement for all trusts to complete an **assurance statement** confirming implementation of the 7 Immediate and Essential Actions (for all NHS Trusts) contained in the Ockenden Report. As mentioned previously, the 7 IEA themes contain 25 specific actions to address. However, this letter set out specific requirements for trusts to address and present progress against 12 of these in the first instance, which are termed 'urgent clinical priorities', to their next meeting of the Board of Directors in public. These comprise (extracted from the letter):

1) Enhanced Safety

a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly

b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

2) Listening to Women and their Families

a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services

b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

3) Staff Training and working together

a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.

b) The report is clear that joint multi-disciplinary training is vital, and therefore we will by publishing further guidance shortly, which must be implemented, In the meantime, we are seeking assurance that a MDT training schedule is in place.

c) Confirmation that funding allocated for maternity staff training is ring fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

4) Managing complex pregnancy

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place

b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

5) Risk Assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

6) Monitoring Fetal Wellbeing

a) Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

7) Informed Consent

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

***Workforce** - the report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.*

Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation.

*To support these discussions, we are asking Trusts to complete and take to your board the **assurance assessment tool,** which draws together elements including:*

1) All 7 IEAs of the Ockenden report,
2) NICE guidance relating to maternity,
3) Compliance against the CNST safety actions, and
4) A current workforce gap analysis

2.11. The completed assurance statement is attached at **Appendix Four**, which confirms the current position against the twelve urgent clinical priorities. Work is underway to address each of the twelve elements, and in light of the report, these have been

reviewed to identify further actions which will be required to ensure full compliance. Members of the Maternity Services senior team will be present at the Board of Directors meeting to provide further information about the approach and to answer any questions from the Board of Directors about the content of the assurance statement, compliance with the requirements and next steps.

As requested, this assurance statement was completed using a template provided. Its content is being transferred into the Trust's action plan format for the purposes of managing and reporting in the future and these have been included in **Appendix Two,** also. In addition, whilst all of the actions from the Ockenden Report will be cross referenced to the existing MIP and MTP, a separate 'stand-alone' Ockenden Action Plan is being produced to facilitate ease of assessment, scrutiny, reporting, and assurance, for the specific actions set out in the Ockenden Report.

The completed assurance statement was submitted to the Regional Chief Midwife on 21st December 2020, as required. The statement was approved on behalf of the Shropshire, Telford & Wrekin Local Maternity and Neonatal System (LMNS) by the Executive Director of Quality for NHS Shropshire and NHS Telford & Wrekin CCG's prior to its submission.

2.12. The letter of the 14th December 2020 stated that Trust's Board of Directors should *"reflect on whether the assurance mechanisms for their trust are effective and, within the local maternity system (LMS), that it is assured that poor care and avoidable deaths with no visibility or learning cannot happen in their own organisation"*.

This is an important issue for the Board to reflect on, particularly following the publication of the Ockenden Report, and on an ongoing basis, as part of the Board Assurance Framework. Whilst governance arrangements have improved, there is still work to do to strengthen these further and, particularly, to ensure the provision of relevant and timely evidence to the Board of Directors against which it can be confident about the level of risk and that there is evidence of improvement and learning. The Board committees have a role to play here, also. A Board seminar session is being organised at which the Board of Directors will review and consider this matter; the outcome of which will be reported to the next Board of Directors' meeting in public.

2.13. A separate paper on the current position with compliance against the Clinical Negligence Scheme for Trusts (CNST) has been prepared by the Director of Midwifery and this is provided as a separate agenda item at today's meeting.

2.14. In addition to the requirements set out in the letter of 14th December 2020, the NHSI/E Midlands region has requested that the Trust develops and submits a comprehensive engagement plan that evidences how the Trust is ensuring that women and their families are listened to and that their voices are heard, with evidence of how this engagement is impacting on the quality of maternity services. The Trust has established a workstream, Workstream 5 – 'Communication and engagement', within the Trust's Maternity Transformation Plan; however, this plan is still in its early stages. For this to be meaningful and achieve the required objectives, it is essential that this work is progressed sensitively and properly with the appropriate stakeholder involvement and engagement. This plan will continue to develop over time, building on the experience of and input from stakeholders. The first draft version of the Communication and Engagement Plan is attached at **Appendix Five**. This requires further work, with co-design being a core principle, and key to the ongoing development of this plan will be the elements set out in actions 5.1 and 5.2; each of which is underway, as follows:

5.1 Continue work with the Expert External Advisory Panel, chaired by Dr Bill Kirkup and the Trust's Communications Support team to develop an engagement/involvement strategy and plan for women and families, including those that have been impacted by care at SATH.

A meeting with Dr Kirkup is being arranged for January 2021 with the Chief Executive, Executive Director of Nursing and Programme Director – Maternity Assurance to discuss and agree how to progress this.

5.2 Establish Communication and Engagement Liaison Group comprising membership including Maternity Voices Partnership and Service User representation. This group is being established to work with the Trust on developing its overall approach and plan to ensure that women and families are involved in their care, are listened to and are involved in service developments and service evaluation.

The inaugural meeting of the Communication and Engagement Liaison Group is planned for 06 January 2021. Membership of this includes senior members of the Maternity Voices Partnership (MVP) Chair, MVP Vice Chair, MVP Co-ordinator, MVP Service User Volunteer, Maternity Liaison Health Visitor Volunteer and SATH maternity and neonatal MDT staff.

2.15. The draft Communication and Engagement Plan at **Appendix Five** was submitted to the NHSI regional office on 28 December. This plan will continue to be developed, and progress against this plan will be reported to the Board of Directors on a regular basis.

3. STATUS OF REQUIRED ACTIONS

In response to the publication of the Ockenden report, the subsequent NHSI/E letter of 14th December and the additional requirements for NHSI/E Midlands, a number of specific deadlines are set out for the Trust to meet, as described earlier in this report. However, for ease, the following table summarises the actions required and the current status of each:

Requirement	Required Date	Status
Receive the Ockenden Report at the next Trust Board meeting in public	Next Trust Board meeting in public	This report is received at today's meeting - 07/01/21
Completed Assurance Statement to be submitted to Regional Chief Midwife (and shared with LNMS)	5pm on 21st December 2020	Submitted to Regional Chief Midwifery Officer on 21st December 2020 Assurance Statement at **Appendix One** of this report. Submitted statement on behalf of the LMNS. This is to be shared with the full LMNS at its next meeting in January 2021
Listening and Engagement Plan for woman and family voices	29th December 2020	Submitted to Regional Director, Regional Chief Nurse and Regional Chief Midwife for

		NHSI/E Midlands on 28th December 2020 Draft Communication and Engagement Plan is at **Appendix Five** of this report
Workforce Plan (to meet Birthrate Plus Standard to be presented to the Trust Board)	31st January 2021	Current position provided in Assurance Statement at **Appendix Four**

4. SUMMARY

The first Ockenden Report into maternity services at the Trust is an extremely harrowing and concerning read. It highlights significant failings at the Trust's maternity services and the impact this has had, and continues to have, on the families concerned. It is only due to their determination to get answers that this review was ever established. This must never happen again and the Trust must learn from its failings and address them without delay.

5. ACTION REQUIRED OF THE BOARD OF DIRECTORS

The Board of Directors is requested to:

- Receive and review the first Ockenden Report (2020)
- Undertake a Board seminar session to reflect on whether the assurance mechanisms are effective and provide sufficient evidence of action and learning and report back to the next board of directors meeting in pubic.
- Decide if any further information, action and/or assurance is required.

Mike Wright
Programme Director
Maternity Assurance
December 2020

Appendix One -	The Ockenden Report (Oct 2020)
Appendix Two -	Current position against the Local Actions for Learning and Immediate and Essential Actions(First Draft)
Appendix Three -	Maternity Improvement Work
Appendix Four -	Assurance Statement
Appendix Five -	First Draft Maternity Services - Communication and Engagement Plan