The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
14 April 2022

Agenda item	061/22			
Report	The Ockenden Report – Final Report			
Executive Lead	Director of Nursing			
	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, BAF3	
	For decision / approval		**Link to risk register:**	
	For review / discussion		CRR 16, 18, 19, 23, 27 7 31	
	For noting			
	For information	√		
	For consent			
Presented to:	Directly to the Board of Directors			
Dependent upon (if applicable)**:**				
Executive summary:	The Board of Directors is requested to: • Receive this report • Approve the actions being taken on receipt of the report • Decide if any further information, action and/or assurance is required			
Appendices:	N/A			
Lead Executive:				

1.0 PURPOSE OF THIS REPORT

1.1 This report presents the final Ockenden Report[1] to the Board of Directors for its consideration. Also, this report sets out the actions arising from this review and how the Trust is progressing them.

2.0 THE OCKENDEN REPORT – FINAL – 30th MARCH 2022

2.1 The final report of the Independent Review of Maternity Services at the Trust, chaired by Mrs Donna Ockenden, was published on Wednesday 30th March 2022. This report follows on from the first report from this review, which was published in December 2020 and was presented to the Board of Directors at its meeting in public on 7th January 2021.

2.2 There can be no substitute for reading this final report and considering it in full. Therefore, it is important that this summary is read in conjunction with the full report, which can be accessed via the following hyperlink: OCKENDEN REPORT - FINAL (donnaockenden.com)

2.3 The report is very harrowing to read and sets out significant or major failings in maternity care services at the Trust, predominantly between 2000 and 2019.

2.4 In addition to being launched by Mrs Ockenden in Shrewsbury on Wednesday 30th March, the report was presented in Parliament by the Secretary of State for Health and Social Care on that day.

2.5 On behalf of the Trust, the Chief Executive issued the following statement:

Today's report is deeply distressing, and we offer our wholehearted apologies for the pain and distress caused by our failings as a Trust.

"We have a duty to ensure that the care we provide is safe, effective, high quality, and delivered always with the needs and choices of women and families at its heart.

"Thanks to the hard work and commitment of my colleagues, we have delivered all of the actions we were asked to lead on following the first Ockenden Report, and we owe it to those families we failed and those we care for today and in the future to continue to make improvements, so we are delivering the best possible care for the communities that we serve."

2.6 The publication of the report has attracted significant local, regional, and national media attention.

2.7 The final report covers the review of the maternity care of 1,486 families and, from these, 1,592 clinical incidents.

2.8 The report describes thematic and repeated failures in care, failures to safeguard mothers and babies, failing to investigate when things had gone wrong, alongside failures to learn and improve. It describes that, had the care of a significant number of women and babies been managed differently, then the outcomes from them may have been different. Also, that due learning and better adherence to approved procedures, practices and guidelines may have prevented further deaths of women and babies.

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[1] 30 March 2022. Crown Copyright. Ockenden Report – Final. Findings, Conclusions and Essential Actions from the Independent Review of maternity Services at the Shrewsbury and Telford Hospital NHS Trust.

2.9 The report includes case examples and the experiences of some women and families alongside a chronology of events, reports and external reviews of the Trust's maternity services during the period under review.

2.10 Alongside the reported failures in care, governance, assurance, systems and processes, the review found associated failures in clinical and corporate leadership at the Trust.

3.0 ACTIONS FOR THE TRUST TO IMPLEMENT FROM THE REVIEW

3.1 The first report from the Independent Review (December 2020) set out specific actions for this Trust to implement, and others for all provider of maternity services in England to implement. These comprised 27 Local Actions for Learning (LAFL's) for this Trust and seven Immediate and Essential Actions (IEA's), comprising a subset of 25 actions, for all trusts. This resulted in 52 actions for this Trust to implement.

3.2 The Board of Directors will be aware, from the Ockenden Report Progress report agenda item presented earlier at today's meeting, that good progress has been made by the Trust in implementing the required actions from the first report. Work continues to deliver the remainder, all of which are dependent upon regional and national actions being taken.

3.3 The final Ockenden Report (March 2022) sets out additional Local Actions For Learning for the Trust, and additional Immediate and Essential Actions for all providers of NHS maternity care in England to implement.

3.4 These comprise:

Domain	Number	Themes Covered
Local Actions for Learning (This Trust)	66	• Improving management of patient safety incidents • Patient and family involvement • Support for staff • Improving Complaints Handling • Improving Audit Process • Improving Guidelines Process • Leadership and Oversight • Care of Vulnerable and High-Risk Women • Fetal Growth Assessment and Management • Fetal Medicine Care • Diabetes Care • Hypertension • Consultant Obstetric Ward Rounds and Clinical Review • Escalation of Concerns • Multidisciplinary working • Fetal Assessment and Monitoring • Specific to Midwifery-Led Units and Out-of-Hospital births • Maternal Deaths • Obstetric Anaesthesia

		• Neonatal • Postnatal • Staff Voices • Supporting families after this review is published
Immediate and Essential Actions to improve maternity care across England (All providers of NHS maternity care in England, including this Trust)	92	• Workforce planning and sustainability • Safe Staffing • Escalation and accountability • Clinical Governance Leadership • Incident Investigation and Complaints • Learning from Maternal Deaths • Multidisciplinary training • Complex antenatal • Preterm birth • Labour and Birth • Obstetric Anaesthesia • Postnatal Care • Bereavement Care • Neonatal Care • Supporting families
Total Actions for this Trust to implement	158	

4.0 ACTION TAKEN ON RECEIPT OF THE REPORT

4.1 On receipt of the report, the following actions have been taken:

4.1.1 The maternity services senior team, supported by corporate colleagues, have a commenced a gap analysis against all the new actions and this work will continue at pace.

4.1.2 The first version of the revised action plan will be taken to the Maternity Transformation Assurance Committee on Tuesday 10th May 2022.

4.1.3 The revised and refreshed Ockenden Report Action Plan and accompanying report will be presented to the Board of Directors' meeting in public on Thursday 12th May 2022.

4.1.4 The next Ockenden Report Assurance Committee (ORAC) will take place on Tuesday 21st June 2022. This meeting will discuss the findings of the final Ockenden Report and consider the Trust's progress against the required actions. This meeting will be live streamed in public.

5.0 SUMMARY

5.1 The final Ockenden Report (2022) is very difficult to read as it represents systematic failures in care, governance, and leadership at the Trust over a large period.

5.2 The Trust would like to thank Mrs Ockenden and her team for the review, the report and the associated actions arising from it.

5.3 The Trust has apologised to those women and families affected by these failings and has given its commitment to continuing to learn and improve, to deliver the best possible services for the communities it serves.

5.4 Improvements have been made since the publication of the first Ockenden Report (2020), but the Trust acknowledges that there is still more to do.

5.5 This work continues at pace and with the same energy and commitment to the new actions from this final report that it has given to those that arose from the first report.

6.0 ACTION REQUIRED OF THE BOARD OF DIRECTORS

6.1 The Board of Directors is requested to:

- Receive this report
- Approve the actions being taken on receipt of the report
- Decide if any further information, action and/or assurance is required

Hayley Flavell
Executive Director of Nursing
April 2022