Report to:	**Public Trust Board**	**Agenda item:**	**13**
Date of Meeting:	**27 January 2021**		

Title of Report:	**Ockenden Review of Maternity Services**
Status:	**For information**
Board Sponsor:	**Lisa Cheek, Director of Nursing and Midwifery**
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Appendices	**Appendix 1: Assurance report**

1. Executive Summary of the Report

On Thursday 11 December 2020, the first report of the independent review into maternity services at the Shrewsbury and Telford Hospital NHS Trust was published. The Ockenden review outlines the learning and the immediate and essential actions for the Trust and the wider system to improve safety in maternity services for the Trust and across England.

Following commencement of the review in 2017, the number of family cases to be considered has increased from the original 23 to 1,862, with the majority of incidents occurring between the years 2000 to 2019.

Due to the rise in the number of family cases for review, the team agreed to publish this first report which makes clear recommendations in the form of Local Actions for Learning and Immediate and Essential Actions for the Trust and maternity services across England in order to improve maternity safety.

7 Immediate and Essential Actions (IEA) were identified in the report to bring about lasting improvements in maternity services. The Trust submitted a letter to the Regional Chief Midwife and national team on 21st December 2020 committing to the implementation of the Urgent Clinical Priorities.

Following the initial submission a further more detailed Assessment and Assurance template was required to be submitted by the 15th January 2021. Due to concerns raised by Trusts to the national team around the short time frame an extension to the submission date to 15th February 2021 was agreed. As well as the Assessment and Assurance template, trusts will be required to upload evidence onto a portal that will be available.

This paper summarises the essential actions recommended by the Ockenden Report into Maternity Services for the attention of the Board and the maternity services commitment to continue to improve safety and quality of care.

2. Recommendations (Note, Approve, Discuss)

For noting

3.	Legal / Regulatory Implications
Initial assurance required to be submitted to NHS England and NHS Improvement by 15th February 2021.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
A failure to implement the recommendations could risk the Trusts registration with the CQC and the reputation of the Trust	

5.	Resources Implications (Financial / staffing)
Resource implications will be defined in action requirements	

6.	Equality and Diversity
All services are delivered in line with the Trusts Equality and Diversity policy	

7.	References to previous reports
NA	

8.	Freedom of Information
Public	

Ockenden Report on Maternity Services

Introduction

In 2017, the previous Secretary of State received a letter from bereaved families where babies and mother had died or potentially suffered significant harm whilst receiving maternity care at Shrewsbury and Telford NHS Trust. He commissioned an external enquiry initially to include 23 cases. This number grew and to date 1,862 families are involved, with the majority of incidents occurring between the years 2000 to 2019.

On 10th December 2020 the Ockenden Report into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust was published. This report presented emerging findings and recommendations from the independent review of maternity services. The full report can be found at: Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust

This paper summarises the actions recommended by the Ockenden Report into Maternity Services for the attention of the Board.

The Report includes seven Immediate and Essential actions (IEA) and are summarised below.

1. Enhanced Safety

- Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.

- Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

2. Listening to Women and their Families

- Maternity services must ensure that women and their families are listened to with their voices heard.
- Confirmation of a non-executive director who will support the board safety champion and bring a degree of independent challenge and ensure women's voices are heard.

3. Staff Training and working together

- Implement consultant led ward rounds twice a day and 7 days a week
- Multidisciplinary training is vital
- The trust should confirm that CNST Maternity Incentive Scheme refund is used exclusively for improving maternity safety.

4. Managing complex pregnancy

- There must be robust pathways in place for managing women with complex pregnancies
- Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

5. Risk Assessment throughout pregnancy

- Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

6. Monitoring Fetal Wellbeing

- All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

7. Informed Consent

- All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services in England were asked to submit assurance signed off by the Trusts Chief Executive and Lead for the Local Maternity System by 21st December 2020 with their compliance with the 7 Immediate and Essential actions.

Following the initial submission a further more detailed assessment and assurance tool was requested for submission by the 15th January 2021. This deadline has since been revised to 15th February 2021. Trusts will also be required to upload evidence onto a portal which will be made available.

Our Response

Our initial review showed compliance in the majority of the immediate and essential actions. 3 areas were identified where further actions were required in order to achieve compliance:

- Action 2 Listening to women and families. The requirement is for Trusts to create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. The aim is to nationally co-produce a framework, including a standard job description, training package and principles for establishing a network. There will be a clear process so that women and families know how to

contact the advocates. This will also include mechanisms for contracting advocates so they remain independent and funding arrangements.

- Action 3 Staff training and working together. The requirement is for the implementation of consultant led labour ward rounds twice daily, 7 days a week. Consultant led labour ward rounds take place twice daily 5 days a week and once daily ward rounds have been in place at weekends. Maternity services are currently reviewing the increased requirement of increased multi-disciplinary ward rounds. The service is currently able to mitigate the increased Consultant presence to attend weekend ward rounds until the permanent plan is in place.

- Action 5 Risk assessment throughout pregnancy. The requirement is for all women to be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. Maternity services has introduced documented risk assessments at each contact as a requirement and a quarterly audit has been introduced.

The Director of Nursing and Midwifery is the executive lead for the Trust's implementation of the report's recommendations.

The Director of Nursing and Midwifery and the Non-executive Director lead have met with the maternity services team and reviewed immediate gaps and actions.

An assessment of the Trust's compliance with the requirements of each of the essential actions is being undertaken and the Board of Directors will be updated on this work.

Recommendations

The Board is asked to receive and note the Ockenden Report on Maternity Services.