Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 24 May 2022

Subject	Ockenden – Final Report
Supporting TEG Member	Chris Morley, Chief Nurse
Author	Chris Morley, Chief Nurse
Status[1]	D

PURPOSE OF THE REPORT

To provide the Board of Directors with information regarding the actions being taken nationally and by the Trust in response to the Ockenden Final Report.

KEY POINTS

- The Ockenden Final Report from the independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Foundation Trust was published on 30 March
- All Trusts received a letter on 1 April from NHS England setting out the actions being taken nationally in response to the report, as well as those to be taken by individual Trusts
- Nationally, significant investment has been agreed to kick start transformation of maternity services with investment of £127m over the next two years, on top of the £95m annual increase that was started last year.
- Actions taken by the Trust in response to the report include; sharing with relevant staff, promoting Freedom to Speak Up in maternity services; and sharing health and wellbeing support for staff in maternity services.
- There is a specific recommendation on Maternity Continuity of Carer (MCoC)
    - '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'.
- Currently MCOC is suspended at the Trust whilst the position on midwifery staffing is further improved.
- It is anticipated that further actions from the Ockenden Final report will be outlined, once the Kirkup report into East Kent Hospitals has been published as it is likely that the recommendations of these two reports will overlap.

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Deliver Excellent Research, Education & Innovation	✓
6	Create a Sustainable Organisation	

RECOMMENDATIONS

That the Board of Directors debate the actions taken by the Trust in response to the Ockenden Final report and the letter from NHS England and confirm that they support the decision that currently MCoC provision at the Trust should remain suspended.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
Board of Directors	24 May 2022	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

1.0 INTRODUCTION

The Ockenden Final Report from the independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Foundation Trust was published on 30 March and is available via the following link Ockenden – Final report.

All Trusts received a letter on 1 April from NHS England setting out the actions being taken nationally in response to the report, as well as those to be taken by individual Trusts (appendix 1).

2.0 NATIONAL ACTIONS

The letter highlighted that there had been significant investment to kick start transformation of maternity services with investment of £127m over the next two years, on top of the £95m annual increase that was started last year. This is intended to fund; further workforce expansion; leadership development; capital to increase neonatal cot capacity; additional support to Local Maternity and Neonatal systems; and retention support.

3.0 ACTIONS REQUIRED OF TRUSTS

The letter outlines a number of actions to be taken by individual Trusts, as follows:

- The Ockenden report should be taken to your next public Board meeting.
- The report should also be shared with all relevant staff. *As well as sharing widely throughout maternity services, the report is also to be discussed at the Management Board Briefing to highlight the lessons from the report that apply outside of maternity services for discussion and onward dissemination*
- Action should be taken to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:
    1. Safe staffing levels
    2. Well trained workforce
    3. Learning from incidents
    4. Listening to families

  All of these elements are covered as part of the Maternity Improvement Programme currently being progressed through the Maternity Improvement Board.

- Every trust board is expected to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. *Within the maternity service there are a number of safety champions at service level as well as an Executive and Non-Executive Champion, detail of these champions is being recirculated to all staff so that they can raise concerns with these champions if they wish. This is in addition to the existing Trust arrangements to encourage staff to speak up.*
- Signposting colleagues in maternity services to additional health and wellbeing support. *Specific wellbeing support for staff in maternity services as well as the 'wellbeing wheel', a pictorial summary of all STH wellbeing support, was communicated to staff in maternity services during April.*
- Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care. *Collaborating with the Maternity Voices Partnership, the team in maternity services are co-producing information and videos for women about their maternity journey. This work is carefully considering the diverse needs of the women and families that we serve. In addition, all women currently receiving antenatal care have been sent a letter offering the chance to raise any worries or concerns they may have following the recent publicity about maternity services following the publication of the Ockenden and other reports about maternity services.*

3.1 Midwifery Continuity of Carer

The final Ockenden report included 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'.

Trusts are asked to make one of the following decisions for their maternity services:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC but can meet the safe minimum staffing requirements for existing MCoC provision should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

As discussed at the Board of Directors in March 2022, the decision was taken last summer to suspend the implementation of MCoC at the Trust, due to acute staffing pressures. This remains the position and so is aligned with the third of the options above. Work continues to further improve the staffing position alongside a plan to restart MCoC when further staff have been recruited.

4.0 NEXT STEPS

The letter concludes by requesting that Boards assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken and necessary assurance of implementation is in place.

The action plan following the most recent CQC inspection of maternity services was discussed at the Quality Committee on 16 May 2022 and a monthly report on maternity and neonatal safety is now being discussed at the Board of Directors from this month going forwards.

At a meeting with the maternity team from North East and Yorkshire recently, it was highlighted that further actions from the Ockenden Final report would be outlined, once the Kirkup report into East Kent Hospitals has been published as it is anticipated that the recommendations of these two reports will overlap. Further updates on these reports will be provided in the monthly maternity and neonatal safety report.

Official
Publication approval reference: B1523

To:

- NHS Trust and Foundation Trust:
  - Chief Executives
  - Chairs
  - Chief Nurses
  - Chief Midwives
  - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

CC:

- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes 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.' (*IEA 2, Safe Staffing page 164)

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. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard	**Ruth May**	**Professor Stephen Powis**
NHS Chief Executive	Chief Nursing Officer	National Medical Director