Cover Sheet

Trust Board Meeting in Public: Wednesday 25 May 2022

TB2022.038

Title:	**Ockenden Report and Maternity Services**

Status:	**For Discussion**
History:	This report is adapted from the BOB spotlight on Maternity services to support Board discussions in response to the publication of the final Ockenden Report in May 2022
Board Lead:	**Chief Nursing Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper is adapted from the Buckinghamshire, Oxfordshire, and Berkshire Integrated System (BOB ICS) review of maternity services with additions to update on OUH specific work, the OUH assessment against the final Ockenden Report and a short summary of outcome data.
2. The publication of the interim report by Donna Ockenden in December 2020 stipulated that all maternity Trusts in England and Wales must comply with seven Immediate and Essential Actions (IEAs)1 and detailed in Appendix 1.
3. As required by NHS England the level of compliance with the seven IEAs was assessed as of 15 April 2022. All three Trusts in the BOB ICS state that they are making good progress with achieving full compliance.
4. Along with Trust Boards, The Local Maternity and Neonatal System (LMNS) has a critical role in ensuring that the ICS responds to the recommendations made in the Ockenden report and any subsequent reports and that additional responsibilities are also met

Recommendations

5. Given the significance of the Ockenden Report and the staffing challenges maternity services face, the Trust Board is asked to note the approach being taken , in particular:
   - To receive the Final Ockenden Report
   - To note the initial self-assessment against the Final Ockenden 15 IEAs.
   - To support the plan for a Board seminar session focused upon clinical outcomes for this patient group
   - To note the update and the work of the LMNS, particularly in relation to safety and compliance in maternity services in BOB, alongside assurance and transformation.

Contents

Cover Sheet 1
Executive Summary 2
Ockenden Report and Maternity Services 4

1. Purpose 4
2. Background 4
3. BOB Compliance with 7 IEAs from the interim Ockenden report (as of end March 22) 5
4. Compliance with 15 IEAs from the final Ockenden report (as of end May 22)
5. Role of the LMNS in BOB ICS 13
6. Section 7: Maternity Staffing 14
7. Freedom to Speak Up 15
8. PALS/Complaints 16
9. Recommendations 16

Ockenden Report and Maternity Services

1. Purpose

1.1. This paper is adapted from the Buckinghamshire, Oxfordshire, and Berkshire Integrated System (BOB ICS) review of maternity services with additions to update on OUH specific work, the OUH assessment against the final Ockenden Report and a short summary of outcome data.

1.2. The publication of the interim report by Donna Ockenden in December 2020 stipulated that all maternity Trusts in England and Wales must comply with seven Immediate and Essential Actions (IEAs)1 and detailed in Appendix 1.

1.3. As required by NHS England the level of compliance with the seven IEAs was assessed as of 15 April 2022. All three Trusts in the BOB ICS state that they are making good progress with achieving full compliance.

1.4. Along with Trust Boards, The Local Maternity and Neonatal System (LMNS) has a critical role in ensuring that the ICS responds to the recommendations made in the Ockenden report and any subsequent reports and that additional responsibilities are also met

2. Background

2.1. The report into failings at Telford and Shrewsbury Foundation Trust Maternity unit has been labelled the largest review of its kind in NHS history. Over 1400 families were impacted in the 20 years of the review, with over 1500 incidents of poor or dangerous practice, resulting in dire outcomes. These include the deaths and serious, life-changing injuries of mothers and babies. It includes detailed descriptions of the experiences of women and families in these cases; it is devastating, for the families who have suffered from these incidents. Coming at a time where the NHS is short of midwives and doctors, whilst still in the pandemic, Ockenden is likely to have the most significant impact on maternity care ever.

2.2. For the Southeast Region, the first self-assessment of compliance with the seven IEAs from the interim report, was June 2021, with a further assessment at the end of 2021. As of 15th April 2022, the date set by NHSE for trusts to state their levels of compliance with the seven IEAs, all three-trusts in BOB self-report that they have made excellent progress on compliance as below.

3. BOB Compliance with 7 IEAs from the interim Ockenden report (as of end March 22)

	RBFT	OUH	BHT
IEA1 Total			
IEA2 Total			
IEA3 Total	Q19	Q17	
IEA4 Total			
IEA5 Total		Q30, Q31	
IEA6 Total	Q35	Q35, Q37	
IEA7 Total		Q41, Q44	

3.1. The multi-professional team across OUH maternity and neonatal services have undertaken a self-assessment against the Final Ockenden Report that was published on 30 March 2022 which contains a further 15 IEA.2. The self-assessment will require scrutiny and assessment by the Trust assurance team.

4. Compliance with 15 IEAs from the final Ockenden report (as of end May 22)

May 2022		
	Essential Action	**OUH rating**
1. Workforces Planning and Sustainability	Financing a safer workforce: The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	National Recommendation
	Training: Ockenden states that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	The Trust undertake a training needs analysis for all professions and there is funding allocated for midwifery staff – specifically. There is no longer a course available to ensure midwives responsible for coordinating labour ward provided by the Royal College of Midwives (RCM.) The RCM are in the early stages of reviewing this.
2. Safe Staffing	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	OUH have a staffing escalation policy. Clarity is needed in relation to a systematic approach to medical staffing.
3. Escalation and Accountability	Staff must be able to escalate concerns if necessary.	There is not a specific 'conflict of clinical opinion policy' that is felt would be useful.
	There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.	Yearly competence review with education supervisor (ES) is suggested. Register of progression points for non-training grade doctors.
	If not resident there must be clear guidelines for when a consultant obstetrician should attend.	Guidelines updated at the beginning of 2022 with the RCOG 'Roles and Responsibilities of the consultant providing acute care in obstetrics and gynaecology' update of when a consultant should attend.
4. Clinical Governance-Leadership	Trust boards must have oversight of the quality and performance of their maternity services.	A maternity dashboard available, however this is being updated and improved to provide clarity and effective

		review of quality and performance.
	In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	There is a local arrangement for medical lead for maternity governance with paid allocations (PA's).
5. Clinical Governance - Incident Investigation and Complaints	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	There is no specific training available for family engagement. OUH engage regularly in meaningful incident investigations through tripartite meetings with Healthcare Safety Investigation Board (HSIB).
6. Learning from Maternal Deaths	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.	Royal College of Pathologists guidance on maternal deaths is currently under review. There are two specific consultants who conduct autopsies in cases of maternal death, the autopsy/pathology report sent to Her Majesty's Coroner (HMC) +/- the consultant obstetrician looking after mother (with permission of HMC). The post mortem (PM) reports are not available on Electronic Patient Records (EPR) because sensitive, confidential, medicolegal reports. The Coroner's PM reports are owned by HM Coroner. After inquest/HMC investigation/HMC permission, the Consultant Obstetrician can discuss autopsy report findings with family/clinical & governance teams at maternal mortality meeting.
	In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	Maternal deaths are referred to HSIB if meets criteria. Discussed a Serious Incidents Requiring Investigation (SIRI) Forum.

7. Multidisciplinary Training	Staff who work together must train together	Multidisciplinary training days for Obstetric Emergencies, known as the PROMPT course and fetal wellbeing.
	Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.	Staff allocated mandatory training during rostered training weeks.
	Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	Training undertaken prior to commencing on Delivery Suite
8. Complex Antenatal Care	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care	There is a pre-conception clinic available for women. There is also a designated clinic where the team care for women with hypertension. There is a specialist diabetes service available for women. Local guidelines comply with National Institute of Clinical Excellence (NICE) for diabetes and hypertension. OUH prescribe aspirin for women with hypertension and this forms part of the Commissioner's risk assessment on EMIS (Electronic Medical Information System our booking form on Cerner and OUH have a preconfigured letter sent via Cerner for women requiring aspirin.
	Trusts must provide services for women with multiple pregnancy in line with national guidance.	The Trust provides services for women with multiple pregnancy. A known gap . against the national standards is that currently there is not a dedicated specialist midwife for multiple pregnancy in post.
	Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	Hypertension guideline updated in October 2020 to reflect the NICE guidance. Point 12.2.6 Hypertension guideline states "Consider referring women with chronic hypertension requiring treatment and planning a

		pregnancy to the Pre-Pregnancy Counselling Clinic in the Maternal Medicine Unit (Silver Star)."
9. Preterm Birth	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.	The preterm labour clinic and the pre and post pregnancy sessions of the consultants involved in preterm labour birth ensures this is done. With acute presentations of hitherto low risk women, consultant review in Maternity Assessment Unit/Delivery Suite is routine.
	Trusts must implement NHS Saving Babies Lives Version 2 (2019)	Reported through the Maternity Incentive Scheme and existing OUH governance processes.
10. Labour and Birth	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.	South Central Ambulance Service are currently unable to provide accurate transfer times for women to consider due to a range of variables on any one day. A new transfer form has been developed. SCAS have been asked for this and it is being actioned across BOB. This has also been raised with the lead maternity commissioner.
	Centralised CTG monitoring systems should be mandatory in obstetric units	In situ on Delivery Suite
11. Obstetric Anaesthesia	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.	There is currently insufficient clinic capacity to offer routine follow-up appointments. The pathway for outpatient postnatal follow-up needs to be clarified.
	Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric	The OUH hybrid paper/Electronic Patient Record (EPR) maternity record is currently a barrier to improving documentation. Antenatal anaesthetic clinic

	anaesthetic intervention would result in record-keeping that more accurately reflects events.	consultations are documented on EPR and anaesthetic charts are on paper. Roll-out of the Trust wide EPR anaesthesia module has been delayed. Development of digital intrapartum obstetric anaesthetic documentation has been paused until the Trust know what system will be adopted by OUH Maternity Services, in accordance with procurement processes.
	Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	National Team Reccomendation
12. Postnatal Care	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.	Women who require Postnatal readmission (PNRA) prior to 4pm will have consultant review on MAU – beyond this time they will be reviewed on the postnatal ward round. Registrar cover has been relatively affected by Covid to prioritise training whereby possible therefore timely senior postnatal review will fall to consultant level and requires an am ward round # to facilitate timely review of PNRA as well as discharge and deal with the clinically complex care needs of women on the postnatal ward.
	Postnatal wards must be adequately staffed at all times	Additional staff have been rotated/rostered for the postnatal ward. BirthRate Plus review is currently in progress and staffing will be adjusted secondary to outcome recommendations. Minimum of two doctors at Senior House Officer (SHO) level or above responsible for

		and immediately available for postnatal ward between hours of 8 to 5. This may require a review of SHO recruitment/core numbers
13. Bereavement Care	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Work is required on the environment on Delivery Suite to fully meet this standard for all women. The other elements of national bereavement care pathway are in place. This is a known estates challenge, which is acknowledged within the CQC action plan.
14. Neonatal Care	There must be clear pathways of care for provision of neonatal care.	There is a mature neonatal Operational Development Network (ODN) ,which has clear pathways and designation.
	This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	
15. Supporting Families	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision	The perinatal mental health team requires strengthening to fully meet this standard. OUH have recently employed a birth trauma midwife and strengthened the perinatal mental health midwifery role. A bid for additional Psychiatric/ psychotherapy and midwifery input is being prepared.
	Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women	Working with the Maternity Voices Partnership (MVP) Maternity Health Inclusion Group continues and is reported through existing governance processes.

	and their families say they need from their care.	

4.1. National Health Service England Southeast (NHSE) SE Region will be conducting assurance visits to all SE maternity trusts between May and September 2022. The team undertaking visits to OUH will include representatives from NHSE, senior leaders across BOB system including the LMNS. Prior to this, QA visits led by the ICS Interim CNO will take place – The OUH visit is planned for 10 June 2022 and the Assurance Team are working with the Chief Nursing Officer.

4.2. The LMNS has set up an Ockenden Steering Group. This will set the roadmap for the formal oversight of progress on Ockenden but also all aspects of compliance. The CNO is working with the LMNS team to strengthen the governance processes with the OUH Trust Board. Paragraph text.

4.3. Each ICS including BOB, have been given funding for implementation of Ockenden IEAs (Appendix 2). The LMNS is currently working with the three3 trusts to agree where this money should be invested. There will be an expectation that each trust appoints a Designated Ockenden Lead, who has operational responsibility for ensuring the Trust is compliant with IEAs, but also to be the voice of impartiality by holding trusts to account and reporting to LMNS. This will include speaking directly to staff to test strategies and improvements in practice. The role will also include the requirement for peer review across BOB and buddy areas, audit and full collaboration with Maternity Voices Partnerships (MVPs) at every stage of assurance.

4.4. The final Ockenden report gave a clear steer that trust plans to roll out Maternity Continuity of Carer (CoC), as the default model of care by March 2023, should be paused. Each trust should conduct a review of the roll out and make a statement as to their current position. Buckinghamshire Healthcare Trust (BHT) and Oxford University Hospitals (OUH) are fully paused, RBH are continuing with the CoC teams they have already established but will pause the roll out of any further teams at this time.

4.5. Nationally, Board level safety champions are expected to have an overview on maternity safety – the CNO and NED Professor Schapira undertake the roles of Maternity and Neonatal Board safety champions – in advance of improving the service quality dashboard which is in progress, and the development of LMNS dashboard, a clinical outcome board seminar is recommended to take place with key learning from Ockenden to be considered.

5. Role of the LMNS in BOB ICS

5.1. The profile of the LMNS has grown exponentially, due largely to the requirements of the Perinatal Surveillance Strategy requirements, which state that Quality Surveillance for maternity should sit with LMNS's. Ockenden reinforced this and submissions to NHSE for assurance have been navigated through the LMNS. Ockenden Assurance Visits will take place between May and September 2022 at the trusts across BOB, plus 'buddy' visits to our Frimley counterparts, and it is expected that the LMNS will be part of the visiting team alongside NHSE

5.2. As part of Quality Surveillance, BOB is part of a Maternal Medicine Network which is being hosted by Oxford. This is currently in it's infancy. This network covers all of BOB plus Milton Keynes, Frimley, Swindon (and possibly Northampton in the future). Each CCG has contributed funds to this network and contracts are being agreed. Although the network is a new concept, the expectation that each locality has this skilled resource is an expectation highlighted in transformation deliverables and Ockenden

5.3. There is currently no guaranteed future funding to the LMNS for equity from region. This may be resolved later in the year with the possibility of more, but given the highlight on equity, and given that maternity is heavily featured in Core20PLUS5, consideration needs to be given as to how this could be made up from elsewhere.

5.4. Future funding considerations will be important to the success of the LMNS. Currently, only 2 of the current roles (Programme Lead and Admin) are permanent. Other ICS's have formalised the structure of their LMNS's by appointing permanent roles, including Heads of Midwifery, Senior Responsible Officer/Deputy Senior Responsible Officer, Workforce Lead. This commitment provides the gravitas needed to be able to have full visibility of their services in their locality, which includes oversight of improvement plans (e.g. Care Quality Commission) and Ockenden moving forward. A committed structure that oversees maternity at ICB level is necessary to ensure Ockenden, Core20PLUS5, Perinatal Quality Surveillance, Maternity Transformation Plan (as part of the Long Term Plan) are all able to develop robustly across BOB.

5.5. The BOB LMNS implements the Maternity Transformation Programme which includes deliverables from the LTP and Better Births. A high level programme plan has been put together with references to further action plans for each deliverable where appropriate. Meetings are held to progress on these deliverables to a set deadline, budget and target.

5.6. Ongoing workstreams, including workforce and COC, equity, prevention, Perinatal Mental Health, Maternal Medicines Network, are just a number of workstreams currently under way in the LMNS. These are all underpinned by safety. These deliverables are highlighted in the recent BOB LMNS funding letter from NHSE/I. The LMNS and acute trusts engage with the Perinatal Mortality Review Tool (PMRT) process, as part of Ockenden implementation and alongside the Maternity and Neonatal Safety Improvement Programme (MATNEO SIP) collaborative. BOB trusts engage with other trusts within the collaborative to provide external reviewer support.

5.7. The BOB LMNS Safety Lead is currently the external reviewer for RBH and OUH and awaiting invitations for Bucks PMRT. Each Trust holds PMRT meetings as per the Perinatal Quality Surveillance model, have an MDT panel and use the PMRT National Tool.

6. Section 7: Maternity Staffing

6.1. England is approximately 2000+ midwives short and so the impact of the report on staff confidence and morale is concerning. All trusts in BOB are experiencing significant pressures on their maternity services and continue to see the impact of Covid absences. OUH sickness absence at 10% approx., 11.78WTE vacancy rate. BHT sickness absence at 8%, 13.75WTE vacancy factor. RBFT sickness absences is at 8%. Note these figures are very fluid with the current surges that take place with COVID throughout the year and may increase sickness absence substantially at certain times of the year .

6.2. OUH have relocated staff as per their escalation plan, from all areas of the service, to keep women and families safe during their antenatal, intrapartum, and postnatal journey. Two of our OUH Midwifery Led Units are currently closed to intrapartum care but continue to offer antenatal and postnatal services with plans to reopen once safe staffing levels have been reached. Wycombe Birth Centre in Bucks has been closed to all care since 2021 and currently remains closed.

6.3. Staff survey report/results (from the trusts maternity workforce) in 2021, which are based on nine areas of staff satisfaction, are variable across BOB. The measurements in the survey include ‘having a voice that counts’, ‘compassionate and inclusive’, ‘safe and healthy’. Buckinghamshire scored the highest for workplace satisfaction and on par with other departments in the trust. Royal Berkshire ranked next, with satisfaction levels slightly lower than other departments in the trust. John Radcliffe scored least well, with

consistently lower levels of satisfaction than expressed elsewhere in the trust. (Appendix 4).

7. Freedom to Speak Up

7.1. After the Mid Staffordshire NHS Foundation Trust investigation in 2013, all NHS trusts were requested to appoint a Freedom to Speak Up (FtSU) Guardian. Guardians work with all staff to help NHS trusts become more open and transparent, and for employees to feel able to 'speak up' without fear of the consequences. They offer support and advice for staff who speak up, or are supporting a colleague who is speaking up, feedback on investigations and the conclusions, immediate action if patient safety is compromised. The CQC considers as part of the well led domain the adequacy of a trust's freedom to speak up arrangements. The LMNS has reviewed the freedom to speak up arrangements at each of the trusts.

Trust	FtSU	Additional information
OUH	One Guardian and local guardian on each site	Individuals contacting the FtSU are offered a meeting to discuss concerns and the approach is set out on the trust website.
BHT	One Guardian	All trust staff are informed on how to contact the guardian
RBH	One Guardian	Details on the FtSU guardian is contained on the trust website and how to contact the FtSU for example text, email or twitter connection

7.2. OUH maternity services had an unannounced visit by CQC in 2021 which rated the department as 'requires improvement', this was following concerns raised by members of staff on the unit. An action plan was put into place. CQC representatives on the LMNS SI panel and Board state that there is good progress on the plan, however the LMNS would like more detailed oversight of the progress, so that the whole of the BOB LMNS can benefit from the learning.

7.3. The action plan goes to BOB and reporting is by exception it forms part of the perinatal quality surveillance report.

8. PALS/Complaints

8.1. Complaints are monitored by both individual Trust Boards and the LMNS using the information contained in the trust dashboards. Additionally, Maternity Voice Partnerships (MVPs) undertake surveys each quarter and extract themes from this for the LMNS board. Currently trusts address feedback of key themes and set up projects to improve services based on this but there needs to be LMNS oversight over this and potential funding initiatives. MVPs are being further funded to ensure there is adequate resource to hear service user feedback, the LMNS plan to ensure there is a robust process to address themes from MVP and complaints as part of the LMNS Board. Themes are identified at Board and LMNS ask for the Trusts to respond, with further analysis where needed and subsequent feedback to board. This is a standing item on the board agenda.

9. Recommendations

- To receive the Final Ockenden Report.
- To note the initial self-assessment against the Final Ockenden 15 IEAs.
- To note the update and the work of the LMNS, particularly in relation to safety and compliance in maternity services in BOB, alongside assurance and transformation.
- To support the action to plan a Board Seminar focused upon clinical outcomes for this patient group – scope to be agreed with Executives and the Chairman.

Appendix 1

Senior Midwife Donna Ockenden was commissioned by NHSI to conduct a review into the serious failings in the Telford and Shrewsbury Foundation Trust Maternity and Neonatal Services in 2017. An interim report was published in December 2020i, which laid out 7 Immediate and Essential Actions (IEAs) that all maternity trusts should commit to comply with. These are:

1. **Enhanced Safety**
a. A plan to implement the Perinatal Clinical Quality Surveillance Model
a. All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

1. **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
a. 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.

1. **Staff Training and working together**
a. Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
a. The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, we are seeking assurance that an MDT training schedule is in place.
a. Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

1. **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
a. Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

1. **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.

1. **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.

1. **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.

Appendix 2

Summary of IEAs where funding can be spent)

Appendix 3 – Links

Interim Ockenden report (Dec 2020)
OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITALNHS TRUST (donnaockenden.com)

Final Ockenden Report (March 2022)
Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust - final Ockenden report (publishing.service.gov.uk)

Core 20PLUS5 – An approach to reducing health inequalities
NHS England » Core20PLUS5 – An approach to reducing health inequalities NHS England » Equity and equality: Guidance for local maternity systems Maternity

Transformation Programme (2020, previously Better Births 2016) NHS England » Maternity Transformation Programme

Patient Safety Strategy (updated 2021)
Report template - NHSI website (england.nhs.uk)
MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | NPEU (ox.ac.uk)
Maternity investigations | HSIB

Appendix 4 Staff Survey results

From the 2021 NHS staff survey results, trusts scored as follows:

https://cms.nhsstaffsurveys.com/app/reports/2021/RTH-directorate-2021.pdf - OUH (see slide 26)
https://cms.nhsstaffsurveys.com/app/reports/2021/RHW-directorate-2021.pdf - RBH (see slide 25)
https://cms.nhsstaffsurveys.com/app/reports/2021/RXQ-directorate-2021.pdf - BHT (see slide 19)