Leicester City Health and Wellbeing Scrutiny Commission

Consolidation Report of UHL Maternity's Learning and Progress from the Ockenden and Kirkup Reports

Lead Director: Julie Hogg, Chief Nurse and Andrew Furlong, Medical Director

Author: Kerry Williams, Head of Midwifery
Liz James, Senior Project Manager

Report version: Final

Purpose of the Report

Following the maternity report to HOSC in June 2022 providing details of the Ockenden report and Leicester Maternity's position at that time, this report provides a consolidated overview of UHL's maternity services learning from the:

- Review of Maternity services in Shrewsbury & Telford (Ockenden report)
- Review of Maternity & Neonatal services in East Kent (Kirkup report)

This paper aims to provide the Committee with information about maternity services' current performance and includes reference to the Perinatal Surveillance Scorecard.

An exception summary of Leicester maternity's performance against the standards from Ockenden is provided below the main report (Appendix 1).

Executive Summary

The initial Ockenden report was published in December 2020 with compliance expected against 7 immediate and essential actions (IEA) by December 2021. The final Ockenden report (March 2022) highlighted a further 15 IEA to improve standards of care. UHL continues to implement and embed these actions with the support of the local maternity and neonatal system (LMNS) and the regional Chief Midwifery Officer.

The Kirkup report published in October 2022 is reflective of the findings from Morecombe Bay (March 2015) and the Ockenden report. Rather than adding to the list of IEAs, Kirkup draws focus to 4 areas for action and makes recommendations for the national teams to address:

- Identifying poorly performing units
- Giving care with compassion and kindness
- Team working with a common purpose
- Responding to challenge with honesty

Themes are identified between Ockenden and Kirkup reports:

- Good governance and data analysis
- Positive culture with open and honest ethos
- Multidisciplinary team working
- Hearing women's feedback
- Leadership
- Organisational behaviours

UHL Maternity Progress

Continual monitoring of Ockenden standards:

UHL maternity was able to provide evidence of compliance for each of the 7 Ockenden IEA's in December 2021 with support and scrutiny provided by the regional chief midwifery officer. The regional perinatal team completed an assurance visit in July 2022 and highlighted points for consideration to support the delivery of a safe and high quality service. We continue to implement and embed these standards and further detail is provided in Appendix 1.

Strengthening governance:

The maternity governance process from ward to Trust Board has been reviewed externally, this has identified a strong structure with some opportunities for improvement. We have also implemented a new Trust Board reporting schedule to ensure the board of directors has oversight of the maternity service. This provides assurance and the information the board is required nationally to be sighted upon. The most recent Maternity Scorecard produced monthly for Trust Board is produced in line with the Perinatal Quality Surveillance Model designed by NHSE to support sharing intelligence from floor to board and is included in Appendix 2.

Over the next quarter we will:

1. Review our performance monitoring alongside system colleagues to ensure it is meaningful, timely, analysed, discussed robustly at MDT governance forums and looks for the signals
2. Recruit 2 renumerated patient safety partners for maternity services

Leadership and Culture:

We have strengthened the midwifery and obstetric leadership team with some additional posts. Our leadership structures are now compliant with the leadership standards set by the Royal College of Midwives.

We are also working hard to understand the culture within maternity and have commissioned Ashley Brooks to lead the empowering voices programme across the service. This is almost complete for the Leicester Royal Infirmary teams. Completion of this will ensure we have a culture that support the safest possible care for women and their families at UHL.

Over the next quarter we will:

1. Welcome our new Director of Midwifery – Danni Burnett
2. Appoint to second Head of Midwifery
3. Develop our safety plan with a key focus on culture
4. Run a bespoke leadership programme for band 7 midwifery leaders funded by HEE

Multidisciplinary Team Working:

Key to the Saving Babies Lives care bundle (2019) is the need for teams to train together. Compliance with training and our ability to run simulations in the clinical setting has been affected by covid-19 restrictions. Training programs will be face to face from January 2023 with an expectation that engagement and compliance will improve.

As part of the empowering voices programme the teams are collectively agreeing a common purpose and objectives to support team working.

Over the next quarter we will:

1. Reinstate face to face training
2. Review the preceptorship programme for newly qualified midwives
3. Launch the maternity strategy
4. Roll out a programme of cultural change (to be commissioned)

Hearing Women's Feedback:

The UHL maternity team is working with LMNS partners to relaunch the Maternity Voices Partnership. We also have strong links with Leicester Mamas who have been involved in service improvements over the past year.

Workstreams are also ongoing to improve outcomes for women from ethnic minority communities and women from areas of deprivation. Action is being taken which focuses on implementing innovative ideas in practice to improve outcomes.

Over the next quarter we will:

1. Relaunch the MVP
2. Recruit 2 renumerated patient safety partners for maternity services
3. Adopt the new patient safety incident review framework to strengthen the voice of families
4. Establish a patient advice and liaison service
5. Review our approach to complaints

Recommendations

The Committee are asked to be assured by the progress to date and note the areas where improvement is required and the plans to address these.

Appendix 1

Exception Summary: Leicester Maternity Ockenden September 2022
(shared with UHL Trust Board October 2022)
Ockenden Final Report, 15 IEA's (published March 2022)

Overview	RAG	Outstanding Actions	Update (if required)
IEA 1: Workforce Planning and Sustainability			
Includes specific standards for labour ward co-ordinators, HDU care & Newly Qualified Midwives and an emphasis on funding MDT workforce & staff training		Workforce planning, recruitment & retention actions ongoing	Establishment reviews complete (Sept 22) & in line with Birth Rate plus establishment setting tool. Progress indicated as amber due to the workforce vacancies.
		2 national actions, awaiting further update re: investment in maternity & neonatal services; and review of BirthRate Plus tool	
IEA 2: Safe Staffing			
Focus on clear escalation processes and associated actions		Update Midwifery Staffing Policy to reflect escalation processes for both community & hospital based teams	Due Nov 22
			Compliant with all other actions however amber reflects reality of day to day operational pressures
IEA 3: Escalation and Accountability			
Need for clear guidance which supports all staff to escalate clinical concerns.		Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Consultant PA's increased. Focus on increasing weekend cover with recruitment & job plan reviews in progress
IEA 4: Clinical Governance – Leadership			
Reinforces need for Trust Board oversight of maternity governance. Midwifery & obstetric leadership needed through governance, guidelines & audit.			Compliant with all actions
IEA 5: Clinical Governance - Incident Investigation and Complaints			
Focus on investigations being meaningful for families and lessons being learnt in a timely manner in practice.		Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Additional resource for governance team in place, rapid reviews & associated actions implemented. Embedded compliance Dec 22
		All maternity services must involve service users (ideally via their MVP) in developing complaints response processes.	Engaged in redesign of MVP, re-launch date subject to ICB procurement process. Standards from national recommendations included in this workstream.
IEA 6: Learning from Maternal Deaths			

Standards around post-mortems, joint investigations & timely learning in practice.		1 national action, awaiting further update re: availability of expert maternity pathologists	Compliant with all actions
IEA 7: Multi-Disciplinary Training			
Continues to support MDT training in emergency skills, CTG & human factors		All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events and attendance should be monitored.	MDT training program in place however not consistently meeting 90% compliance expected of CNST – actions in place to achieve across MDT Oct 22
		Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	
IEA 8: Complex Antenatal Care			
Focus on Maternal Medicine Networks, and care for women with multiple pregnancy, diabetes & hypertension.		Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. Supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Plan to develop specialist multifetal clinic (requires midwife recruitment).
IEA 9: Preterm Birth			
Systems & processes to support women at risk of preterm birth			Compliant with all actions
IEA 10: Labour and Birth			
Includes care outside hospital setting, IOL pathways and centralised CTG monitoring systems.		All women must have full clinical assessment including place of birth	Risk assessment completed at every contact – monthly audits show improvement but not consistently meeting 90% target
		Midwifery-led units must complete yearly operational risk assessments.	Operational plan being created with annual review date
		Women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit.	Information for women being updated, due Oct 22
		Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs	Awaiting further information from national fetal monitoring group
IEA 11: Obstetric Anaesthesia			
Includes safe staffing, documentation, information for women & follow-ups.		Review documentation in maternity patient records and take steps to improve this where necessary	HoS supporting national work around anaesthetic documentation. Local audit of documentation taking place to inform actions
		The full range of obstetric anaesthesia	Business case agreed to increase

		workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	caesarean section capacity. Implementation process initiated.
		Participation by anaesthetists in the maternity multidisciplinary ward rounds	HoS working to ensure full MDT ward rounds twice each day, due Nov 22
IEA 12: Postnatal Care			
Safe staffing for postnatal care, timely consultant reviews for women re-admitted or unwell postnatally.		Staffing levels must be appropriate for both the activity and acuity on the postnatal ward both day and night.	Further exploration of the best way to monitor acuity on the wards taking place
IEA 13: Bereavement Care			
Focus on compassionate, individualised bereavement care available 24/7.		All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth.	Substantive bereavement team increased to 7 day service. Plan in place to increase training for MDT in bereavement care & to increase number of team trained in post mortem consent
IEA 14: Neonatal Care			
Increasing neonatal critical care cots. Clear pathways of care with advice & support throughout the network		Care that is outside the agreed pathway for neonatal care must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network.	Working with LMNS to agree process for oversight exceptions (network consistency)
		Work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Continued engagement with regional QI projects which support this
		Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit to deliver safe care 24/7.	Business cases for medical, nursing & AHP workforce with ongoing recruitment. Risk of split site working recognised by the Trust.
IEA 15: Supporting Families			
Supporting maternal mental health including specialist psychological support.			Compliant with all actions

Additional actions (not captured above) from NHSE Insight Visit July 2022
Ockenden Initial Report, 7 IEAs (published December 2020)

Overview	RAG	Outstanding Actions	Update (if required)
IEA 1: Listening to women and families			
Includes the roles of safety champions and maternity voices partnership (MVP)		Strengthen MVP role and the relationship between safety champions and service users	Engaged in redesign of MVP, re-launch date subject to ICB procurement process. Evidence of engagement with service users in QI projects
IEA 3: Staff training and working together			
Focus on the MDT's importance in patient safety		Consultant led MDT ward rounds twice each day	Plan to trial new model to increase consultant cover (involves job planning reviews) Auditing monthly
		90% compliance required for MDT training in emergency skills drills & fetal monitoring	Actions being taken to increase compliance across all MDT
IEA 7: Informed consent			
Focus on information available to women		Information available on the maternity website	Current website under review following input from MVP, new internal website launch October 22

Appendix 2

Meeting title:	Public Board of Directors
Date of the meeting:	November 2022
Title:	UHL Maternity Perinatal Quality Surveillance Scorecard
Report presented by:	
Report written by:	Kerry Williams, Head of Midwifery John Barnett, Business Intelligence Specialist

Action – this paper is for:	Decision/Approval		Assurance	x	Update	X
Where this report has been discussed previously						

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The report provides a monthly update of the maternity scorecard, presenting data against key performance indicators and exception report highlighting areas of underperformance and associated actions for improvement.

Impact assessment
N/A

Acronyms used:
Please see abbreviations commonly used in maternity reports

Purpose of the Report

The scorecard is produced in line with the Perinatal Quality Surveillance Model designed by NHSE to support sharing safety intelligence from floor to board.

Executive Summary

The scorecard includes 5 areas of focus:

- Patient Safety
- Workforce
- Training
- Friends and Family
- Outcomes

The scorecard provides monthly data with trends since March 2022. The exception report highlights actions to improve compliance against each underperforming metric.

There are 6 areas of challenge:

- Moderate incidents
- Midwife vacancies
- Staff training compliance
- Friends and family footfall
- % blood loss greater than 1500ml
- % 3rd and 4th degree tears

Recommendation

The board of directors are asked to be assured by the progress to date and note the areas where improvement is required.

Maternity Perinatal Quality Surveillance Scorecard - W&C CMG Month 6 (September) 2022-23

	National Target / Alert Level	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	2022-23 TOTAL / AVERAGE (YTD)	Variation - 12 month period / SPC
PATIENT SAFETY										
Total deliveries (LRI, LGH, SMBC, HB & BBA)	Actual	842	787	809	786	781	850	823	4836	
No. of hospital deliveries at LRI (excl HB & BBA)	Actual	473	463	440	443	431	495	455	2727	
No. of hospital deliveries at LGH (excl HB & BBA)	Actual	344	305	344	315	312	326	343	1945	
No. of hospital deliveries at SMBC Plus HB & BBA	Actual	25	19	25	28	38	29	25	164	
SIs (Obstetrics)	Actual	2	3	1	3	5	1	1	14	
SIs (Neonatology)	Actual	0	0	1	0	0	0	0	1	
Number of Still births - overall total	Actual	5	2	3	3	8	4	3	20	
Still births as %age of Total Deliveries	<0.45%	0.6%	0.3%	0.4%	0.4%	1.0%	0.5%	0.4%	0.4%	
HSIB Referrals	Actual	2	1	0	4	5	1	0	13	
Moderate Incident	Actual	9	5	5	8	5	8	6	7	
Coroner Regulation 28 Requests	Actual	0	0	0	0	0	0	0	0	
WORKFORCE										
Funded Midwife to Birth ratio (UHL complete care) - 1	>1:26.4	1:27.0	1:25.5	1:25.5	1:25.5	1:25.5	1:25.6	1:25.6	1:25.5	
Midwife Vacancies (%)	Actual				14.4%	13.6%	13.6%	15.2%	14.2%	
1 to 1 Care in Labour	Actual	100%	100%	100%	100%	100%	100%	100%	100%	
TRAINING										
% of All Staff attending Annual MDT Clinical Simulation	Actual	78%	81%	83%	86%	88%	87%	90%	86%	
% of All Staff attending NLS Training	Actual	88%	83%	76%	84%	92%	93%	92%	87%	
% of All Staff attending CEFM Training (Theory)	Actual	94%	82%	91%	93%	92%	96%	95%	92%	
% of All Staff attending CEFM Training (Assessment)	Actual	92%	81%	91%	93%	92%	96%	94%	91%	
FRIENDS AND FAMILY										
Maternity Friends & Family - Footfall	>=30% (UHL Target)	19.3%	17.4%	19.7%	15.4%	19.0%	18.3%	22.0%	18.6%	
Maternity Friends & Family - percentage of promoters	>=96% (UHL Target)	96.3%	96.6%	97.3%	95.7%	95.4%	95%	97%	96.1%	
OUTCOME										
Spontaneous Deliveries %	Alert if <51%	47.4%	48.2%	47.3%	46.4%	49.7%	50.0%	44.8%	47.7%	
Caesarean Section Rate - total	Alert if >23%	41.6%	38.5%	39.6%	38.2%	38.7%	38.2%	41.6%	39.1%	
% Blood loss greater than 1500 ml (as a % of total deliveries)	<3.6% (Local Target <=2.7%)	3.3%	2.9%	3.7%	2.9%	4.0%	2.7%	2.9%	3.2%	
% 3rd & 4th degree tears (as a % of total vaginal deliveries)	Alert if >3.6%	1.8%	3.7%	3.3%	2.7%	3.7%	3.0%	3.9%	3.4%	
% of Full term babies admitted to NNU NB:Figures from January 2019 reflect ATAIN: Term admissions to NNU as % of UHL Term births	ATAIN Target <6.0%	4.42%	4.42%	3.31%	5.86%	3.99%	3.51%	4.87%	4.36%	

Maternity Perinatal Quality Surveillance Scorecard – Exception Report
October 2022 (September data)

Metric underperformed	Driver for underperformance	Actions to address the underperformance
Patient Safety		
Moderate incident	• 6 moderate harms reported in September • 1 reviewed and downgraded	• Completed rapid review on 4 of 5 moderate incidents. 1 outstanding is 4th degree tear for consultant review • 1 case taken to perinatal risk group (PRG) no concerns identified about management of care with no recommendations • Remaining cases being discussed at PRG in October • All cases received verbal duty of candour • 1 case referred to HSIB, but was declined as MRI normal • Cluster review to be arranged for 3 Massive Obstetric Haemorrhage with hysterectomies
Workforce		
Midwife vacancies	• Midwifery vacancy 66.71 WTE • Vacancy rate impacting on staff morale, retention and service delivery	• Empowering voices programme commenced at LRI, commissioned further review for LRI and community • 27 newly qualified midwives due to start around November/December 2022 • 2 further external candidates to be interviewed • 2 international midwives to commence in November plus 2 more to interview • Matron for safe staffing post out to advert
Training		
% staff attending MDT simulation training % staff attending CEFM training	• CNST requirement >90% compliance for each staff group	• Engagement from anaesthetic staff to improve compliance • NHSR contacted to review update on compliance indicator changed in October 22
Friends and family		
Maternity Friends & Family - Footfall	• Footfall below UHL target of 30% • Poor compliance with collection in community due to national change of 36-week collection metric	• Team leads encouraging completion at meetings, this has seen slight increase for September. • Community matron to scope text process with patient experience team
Outcomes		
% Blood loss greater than 1500 ml % 3rd & 4th degree tears	• Likely to coincide with Increase in numbers of caesarean sections • National outlier for 3rd & 4th degree tear rates identified through benchmarking	• Work in progress to implement OBS Cymru programme to reduce postpartum haemorrhage • Perineal tears workstream focusing on education and prevention care bundle to improve outcomes