Leicester City Health and Wellbeing Scrutiny Commission

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

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Report version:

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 in respect of the following:

- 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.

Information is provided on the ongoing work to respond to the recommendations of the Ockenden report.

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 generate further insight into the themes around teamwork, professionalism, compassion, responding to investigations, and failures to listen. An extensive program of work has already commenced to improve the culture of the service.

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

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.

UHL Maternity Progress

Continual monitoring of Ockenden standards:

Following the initial Ockenden Report (December 2020) evidence of compliance has been collated and shared with commissioners and regulators against each of the 7 Immediate and Essential Actions (IEAs). Evidence was reviewed and feedback received from NHS England (NHSE) indicating compliance with one exception: external clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. This indicator remains partially compliant with actions taken including: HSIB cluster review; a peer review with Leeds teaching Hospital; an independent desktop review commissioned by LLR ICB) and work with our buddy maternity Trusts to establish a formal process for external review.

The NHSE Regional Perinatal team completed an assurance visit in July 2022 which generated several actions for attention. This included strengthening communication across the service on plans and actions, plus recognition of the impact on compliance due to the lack of a Maternity Voices Partnership (MVP) across the LLR system.

Below are actions which remain outstanding following the feedback from the Insight Visit:

Overview	RAG	Outstanding Actions	Update (February 2023)
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	UHL have engaged in the redesign of the MVP being led by the LLR ICB. Procurement panel conducted February 2023 with successful bidder to be awarded, timeframe for implementation awaits. In addition, there is continuous evidence of engagement with service users in Quality Improvement projects continues to be captured such as: Leicester Mammas engagement and collaboration through the development of the Equity and Equality plans, support with Unicef Baby Friendly Accreditation (BFI) and Breastfeeding Peer Support, development of Red Flags and Symptom Checkers. Plus, further work to improve our communication with women and their families such as development of an App for South Asian Women (JANAM App)
IEA 3: Staff training and working together			
Focus on staff training together and working together.		Consultant led MDT ward rounds twice each day	Insight visit highlighted need for midwife co-ordinator, anaesthetist and consultant to be present as a minimum for compliance. Targeted action based on monthly audits to increase anaesthetic representation and reduce gaps in documenting attendance.
IEA 7: Informed consent			

Focus on information available to women		Information available on the maternity website	A task and finish group has been established to review the maternity website. MVP involvement to be progressed once in place. Multiple innovative solutions to support effective communication with women in progress i.e. CardMedic pilot and the JANAM App

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 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 presented 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 1.

Over the next quarter we will:

1. Complete a stocktake review of all evidence against each of the 15 Ockenden recommendations with an active support and oversight role played by our LLR Local Maternity & Neonatal System (LMNS)
2. Be working with the LMNS and ICB to establish formal reporting (LLR Ockenden Assurance Meeting scheduled for April 2023
3. UHL will establish an executive-led Maternity Assurance Committee (MAC) which will take the lead on assurance in relation to delivery and sustainability of the Ockenden and Kirkup actions.

Whilst establishing MAC, below provides a snapshot of the ongoing work to respond to the recommendations:

Immediate and Essential Actions (IEA)	Examples of Ongoing Actions
IEA1: Workforce Planning and Sustainability	• Funded midwifery staffing in line with Birth Rate Plus • Matron for Midwifery Safe Staffing and Recruitment, Retention, and Pastoral Midwives now in post
IEA2: Safe Staffing	• Safe Staffing for nursing & midwifery policy updated (February 2023) • Refreshed Maternity & Neonatal Escalation Policy aligned to the NHSE Regional Escalation Policy • BirthRate Plus® Acuity summaries included within formal reporting
IEA3: Escalation and Accountability	• Increase in Consultant PA time, focus on weekend and job plans
IEA4: Clinical Governance (Leadership)	• Trust Board oversight in place with standing item of perinatal scorecard and annual work plan • MAC to be established
IEA5: Clinical Governance (Incident Investigation and Complaints)	• Additional resource to support the governance team • UHL involvement in the MVP procurement exercise
IEA6: Learning from Maternal Deaths	• Active Perinatal Mortality Review Group • Rapid Review process in place

	• Close working with Medical Examiners and Learning from Deaths programme
IEA7: Multi-Disciplinary Training (MDT)	• MDT training meets 90% compliance as per NHSR since November 2022 • Face to face training recommenced from January 2023
IEA8: Complex Antenatal Care	• Plans to develop specialist multifetal clinic
IEA9: Preterm Birth	• Focus on improving compliance of Saving Babies Lives Care Bundle (SBLCBv2) – reducing smoking in pregnancy and addressing the variation of antenatal steroids
IEA10: Labour and Birth	• Consultant Midwife leadership on women who choose birth outside of guidelines
IEA11: Obstetric Anaesthesia	• Head of Service national involvement with work on anaesthetic documentation, local audits in place • Business case to build capacity • Improving participation on ward rounds
IEA12: Postnatal Care	• Implementation and embedding BirthRate Plus® acuity tool in the postnatal ward areas
IEA13: Bereavement Care	• Substantive bereavement team increased to 7day service • Training embedded into mandatory training with close monitoring of staff trained in post-mortem consent
IEA14: Neonatal Care	• Business case in development for allied health professionals (AHPs) • Increasing capacity for critical care beds • Refresh of local Transitional Care plans
IEA15: Supporting Families	• Ongoing work to improve access to families requiring specialist support

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 welcomed Danni Burnett, Director of Midwifery, to the team in January 2023.

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 in progress for the Leicester Royal Infirmary, Leicester General Hospital and community 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 second Head of Midwifery – Rebekah Calladine
2. Develop our safety plan with a key focus on culture
3. 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. Compliance with the training standard of the Maternity

Incentive Scheme were achieved in November 2022 and training programs have returned to face to face in January 2023.

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. Review the preceptorship programme for newly qualified midwives
2. Launch the maternity strategy
3. 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 (MVP). Leicester Mamas were commissioned in February 2023 to deliver the MVP.

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.