Leicester, Leicestershire and Rutland Joint Health and Overview Scrutiny Committee

27th June 2022

Progress on Ockenden Immediate and Essential Actions (IEA's) following the publication of the Interim Report (December 2020)

Introduction

This report is to provide the committee assurance that the LLR Local Maternity and Neonatal System (LMNS) has addressed the immediate and essential actions in relation to the Interim Ockenden Report [1]published in December 2020 (Part 1). UHL as the maternity provider has worked closely with system partners and the regional NHSE/I team to submit substantial evidence for assessment and provide confidence in compliance.

The evidence required had to be submitted via a portal by June 2021 and assessed externally, progress was monitored through the monthly LMNS for LLR. The regional team then provided each LMNS and provider Trust with the outcome of compliance. This report will provide a summary of achievement against the immediate and essential actions and provide next steps with the Final Ockenden report [2]Published in March 2022.

Whilst continuing to work through and embed the 7 EIA's from Ockenden (Part 1), we are also preparing to assess ourselves against a further 15 IEAs published in the final Ockenden report (Part 2) on the 31st of March 2022. These actions complement and expand upon the initial IEA's published in the first report as well as new actions. Further details around our plans can be found in Appendix A.

Background

In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

This independent maternity review was to focus on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and new-born babies. In addition, a small number of earlier cases have emerged these are being reviewed by the independent team wherever medical records are available.

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[1] Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. Our First Report following 250 Clinical Reviews (Dec 2020) www.gov.uk/official-documents.

[2] Findings, conclusions, and essential actions from **The Independent Review of Maternity services** at The Shrewsbury and Telford Hospital NHS Trust, Our Final Report (March 2022) www.gov.uk/official-documents.

The total number of families to be included in the final review and report is 1,862. The first interim report was published arising from 250 cases reviewed. The number of cases considered to that point so far included the original cohort of 23 cases.

The review panel identified important themes which must be shared across all maternity services as a matter of urgency and have formed **Local Actions for Learning** within Shrewsbury and Telford Hospitals and make early recommendations for the **wider NHS Immediate and Essential Actions** (IAE).

Findings from the report

Below is a brief summary of some of the findings from the interim report that led to the development of the essential and immediate actions for all maternity services nationally.

Review of the Trust's maternity governance processes:

- Inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.
- Inconsistent multi professional engagement with the investigations of maternity serious incidents.
- In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care.
- Lack of objectively in Serious incident reviews and a lack of consideration of the systems, structures and processes in the reports.
- Limited evidence of feedback to staff following incident review.
- There were examples of failure to learn lessons and implement changes in practice such as in the selection of, or advice around, place of birth for mothers and management of labour overall. There was a failure to escalate concerns in care to senior levels when problems became apparent and continuing errors in the assessment of fetal heart.

It was also found that:

- Incidents not investigated in a timely manner and not investigated using a systematic and multi professional approach.
- Lack of evidence that lessons were learned and applied in practice to improve care.

Labour care and management of complex pregnancy:

- Women were not always risk assessed in a consistent manner that led to incorrect place of birth being identified
- Staff were not trained regularly and appropriately in assessment of fetal monitoring
- Risk assessments were not regularly carried out in labour
- The service did not always follow national guidance or have robust up to date local guidance in place. Where guidance was in place it was not always followed.

Multi professional training did take place however it was not consistent and often not recorded in a way that could provide evidence of completion and funding for essential training and backfill not always ring fenced or supported.

Trust Board did not always have oversight of serious incidents or concerns within the maternity service. Turnover of Executive leadership was shown to have impacted on organisational knowledge and memory.

This is a snapshot of findings from the report, the full report has been reviewed at length both within UHL and in the LMNS.

Immediate and Essential Actions to Improve Care and Safety in Maternity Services across England

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.

Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g., through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.

An LMS cannot function as one maternity service only.

The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.

All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2. Listening to Women

Maternity services must ensure that women and their families are listened to with their voices heard.

Trusts must 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

Each Trust Board must identify a nonexecutive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

CQC inspections must include an assessment of whether women’s voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

Maternity services must ensure that women and their families are listened to with their voices heard.

3. Staff training and working together

Staff who work together must train together.

Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

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.

Women with complex pregnancies must have a named consultant lead.

Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.

The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.

This must also include regional integration of maternal mental health services.

5. Risk assessment throughout pregnancy

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

All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

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.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:

- Improving the practice of monitoring fetal wellbeing
- Consolidating existing knowledge of monitoring fetal well being

- Keeping abreast of developments in the field
- Raising the profile of fetal wellbeing monitoring
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.

The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.

They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.

The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle and subsequent national guidelines.

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 must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care.

Women's choices following a shared and informed decision-making process must be respected.

Current position in Leicester, Leicestershire and Rutland

Our self-assessment against the seven IEA's concluded that we are complaint for majority of actions and where gaps have been identified we have plans in place to address them.

Within the Seven Immediate and Essential actions there are forty-nine criteria to be met and the LMNS submitted one hundred and twenty-seven pieces of evidence to support compliance.

Some of the criteria are in progress but not embedded, these are detailed below:

IAE action 1

External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

The NHSE/I regional Midlands team has created a list of clinical experts from a number of Trusts, however with current clinical pressures in maternity services, releasing clinicians for external reviews is challenging. Currently in LLR, there external review from clinicians in the Quality team from the CCGS who join UHL perinatal risk and perinatal mortality meetings. This team also review any serious incidents declared and review draft and final reports from investigations.

Buddying arrangements are being finalised from two external LMNS's to join LLR LMNS meetings for oversight.

IAE action 2 Listening to Women

Trusts must 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 advocate role is being developed as a regional approach with NHS England oversight, devising a Job description that is consistent nationally, including training for advocates, who will be available for Trusts to engage when meeting with women and their families.

We continue to work closely with out MVP and Leicester Mamma's to ensure our pathways are co-produced in response. A recent example is the engagement of our service users in the co-production of our maternity equity and equality action plans.

IAE action 3 Staff Training and Working Together

Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

One element of this action is particularly challenging, multidisciplinary Consultant led ward wards, night and day, seven days a week-UHL currently have not enough consultants to cover this, recruitment for obstetricians has been ongoing for some months with limited applications. Currently this is provided five days a week and once on a weekend, the evening ward round is discussed by telephone with the consultant on call.

Risks and challenges:

Risk: Staffing pressures at UHL (midwifery): Continue to remain extremely challenging.

Mitigation: Our workforce plan (Appendix A) includes retention, recruitment, and consideration of other roles to support the service acknowledging the national challenges around midwifery supply. The service is reviewing a shortened degree programme for midwifery. We are pushing ahead with our international recruitment and there is ongoing work in relation to recruitment and investment in obstetric staff to to discuss these plans further. Systems are in place within the Trust to review acuity and staffing throughout the day, to ensure safety at all times. Concerns around midwifery staffing have been raised and are on both the Trust and LMNS risk registers as high risk.

UHL maternity service with oversight from the LMNS will continue to provide the families within LLR with safe care, enhanced with listening to women's voices and caring for the staff within the service.

Summary and next steps

The LMNS in LLR had met a number of the actions prior to the interim Ockenden and has embedded and introduced further actions required, two of the three elements above are awaiting a regional response and UHL are actively trying to recruit the number of consultants required to extend delivery suite cover to enable the evening ward round to take place on weekends.

All processes introduced are monitored monthly through audit or spot checks to ensure the actions are continued and reported through the UHL clinical management group Governance board and through the LMNS.

The NHSE/I regional maternity team are visiting UHL maternity services with members from the LMNS in July to review the compliance with the Ockenden IAE actions and speak to staff and the members of the executive team.

NHSE/I have not yet issued the evidence they will require to support our assessment of the newly published 8 IEA's, however our early assessment (in anticipation of the release of Part 2) suggests we have steps in place. Following the formal publication of the final report in March this year we will reassess ourselves against the new 8 IEA's to help us understand progress and devise a plan to address any identified gaps. This will be reported to NHSE/I once they have released the criteria for assessment.

In addition to the above we understand the findings of the current inquiry led by Dr Kirk up into East Kent Maternity services are due to be published later this year. Our benchmarking exercise suggests that the service is overall compliant, with action plans in place where we have rated ourselves against actions we are progressing.

Recommendations

The Joint Health and Overview Scrutiny Committee is asked to:

RECEIVE and note contents of this report.