

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: 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:

- 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.

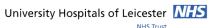
Workstreams are also ongoing to improve outcomes for women from ethnic minority communities and women from areas of deprivation. Action is being taken which focuses on implementing innovative ideas in practice to improve outcomes.

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.



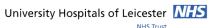
Appendix 1

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 a	nd Sust	ainability		
Includes specific standards for labour ward co- ordinators, HDU care & Newly Qualified Midwives		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.	
and an emphasis on funding MDT workforce & staff training		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 Accour	ntability	1		
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 –	Leader	ship		
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 -	Inciden	t Investigation and Complaints		
Focus on investigations being meaningful for families and lessons being learnt in a timely manner in		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	
practice. IEA 6: Learning from Matern		All maternity services must involve service users (ideally via their MVP) in developing complaints response processes.	Engaged in redesign of MVP, relaunch date subject to ICB procurement process. Standards from national recommendations included in this workstream.	

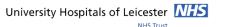
Standards around post-	1 national action, awaiting further	Compliant with all actions			
mortems, joint	update re: availability of expert				
investigations & timely	maternity pathologists				
learning in practice.					
IEA 7: Multi-Disciplinary Train	ng				
Continues to support MDT	All members of the multidisciplinary	MDT training program in place			
training in emergency skills,	team working within maternity	however not consistently meeting			
CTG & human factors	should attend regular joint training,	90% compliance expected of CNST –			
	governance and audit events and	actions in place to achieve across			
	attendance should be monitored.	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	•	1			
Focus on Maternal	Trusts must have in place specialist	Plan to develop specialist multifetal			
Medicine Networks, and	antenatal clinics dedicated to	clinic (requires midwife			
care for women with	accommodate women with multifetal	recruitment).			
multiple pregnancy,	pregnancies. Supported by the NICE				
diabetes & hypertension.	Guideline Twin and Triplet				
	Pregnancies 2019.				
IEA 9: Preterm Birth					
Systems & processes to		Compliant with all actions			
support women at risk of					
preterm birth					
IEA 10: Labour and Birth	'				
Includes care outside	All women must have full clinical	Risk assessment completed at every			
hospital setting, IOL	assessment including place of birth	contact – monthly audits show			
pathways and centralised	51	improvement but not consistently			
CTG monitoring systems.		meeting 90% target			
	Midwifery-led units must complete	Operational plan being created with			
	yearly operational risk assessments.	annual review date			
	Women who choose birth outside a	Information for women being			
	hospital setting are provided accurate	updated, due Oct 22			
	and up to date written information				
	about the transfer times to the				
	consultant obstetric unit.				
	Centralised CTG monitoring systems	Awaiting further information from			
	must be made mandatory in obstetric	national fetal monitoring group			
	units across England to ensure regular	00			
	multi-professional review of CTGs				
IEA 11: Obstetric Anaesthesia					
Includes safe staffing,	Review documentation in maternity	HoS supporting national work			
documentation,	patient records and take steps to	around anaesthetic documentation.			
information for women &	improve this where necessary	Local audit of documentation taking			
follow-ups.	,	place to inform actions			
	The full range of obstetric anaesthesia	Business case agreed to increase			
l l					

	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 readmitted 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	<u> </u>	
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	Constitution with the const	NAC ALTERNATION OF THE LANGE OF THE CONTRACT O
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		Strengthen MVP role and the	Engaged in redesign of MVP, re-	
champions and maternity		relationship between safety	launch date subject to ICB	
voices partnership (MVP)		champions and service users	procurement process.	
			Evidence of engagement with service users in QI projects	
IEA 3: Staff training and wo	rking to	ogether		
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		Information available on the	Current website under review	
available to women		maternity website	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	Х	Update	Х
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

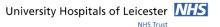
Purpose of the Report

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.

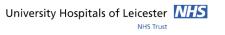
There are 6 areas of challenge:

- 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 2022-23 National TOTAL / Variation - 12 month Aug-22 Target / Mar-22 Apr-22 May-22 Jun-22 Jul-22 Sep-22 AVERAGE period / SPC Alert Level (YTD) 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 1945 No. of hospital deliveries at LGH (excl HB & BBA) Actual 344 305 344 315 312 326 343 No. of hospital deliveries at SMBC Plus HB & BBA 25 Actual 25 19 25 28 38 29 164 SIs (Obstetrics) Actual 2 3 3 5 1 14 SIs (Neonatology) 0 0 0 0 0 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** 0 4 5 1 0 13 Actual Moderate Incident 9 5 8 5 8 6 7 Actual Coroner Regulation 28 Requests 0 0 0 0 0 0 0 0 Actual WORKFORCE Funded Midwife to Birth ratio (UHL complete care) >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 88% 78% 81% 83% 86% 87% 86% Actual 90% Simulation % 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 Actual 92% 91% 93% 92% 96% 94% 91% 81% (Assessment) FRIENDS AND FAMILY >=30% (UHL Maternity Friends & Family - Footfall 17.4% 19.7% 15.4% 19.0% 18.3% 19.3% 18.6% Target) Maternity Friends & Family - percentage of =96% (UHL 96.6% 95.7% 95.4% 95% 96.3% 97.3% 97% 96.1% promoters Target) OUTCOME Alert if Spontaneous Deliveries % 47.4% 48.2% 47.3% 46.4% 49.7% 50.0% 44.8% 47.7% <51% Alert if 41.6% 38.7% Caesarean Section Rate - total 38.5% 39.6% 38.2% 38.2% 41.6% >23% <3.6% % Blood loss greater than 1500 ml (as a % of total (Local 2.9% 2.9% 3.3% 3.7% 4.0% 2.7% 2.9% deliveries) Target <=2.7%) % 3rd & 4th degree tears (as a % of total vaginal Alert if 1.8% 3.7% 3.3% 2.7% 3.7% 3.0% 3.9% 3.4% deliveries) >3.6% MANIMAN LI ATAIN % of Full term babies admitted to NNU 4.87% 4.36% 4.42% 4.42% 3.31% 5.86% 3.99% 3.51% NB:Figures from January 2019 reflect ATAIN: Term admissions to Target NNU as % of UHL Term births <6.0%



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 			
	Work				
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 			
	Traiı				
% 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 a	nd 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 			
	Outco				
% Blood loss greater than 1500 ml	Likely to coincide with Increase in numbers of caesarean sections	Work in progress to implement OBS Cymru programme to reduce postpartum haemorrhage			
% 3rd & 4th degree tears	National outlier for 3 rd & 4 th degree tear rates identified through benchmarking	Perineal tears workstream focusing on education and prevention care bundle to improve outcomes			