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NHS
North East and North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	✓
Official: Sensitive Personal		For information only	

BOARD MEETING 27 September 2022	
Report Title:	**Ockenden Report - Immediate Actions Review**

Purpose of report

- To provide a thematic review following insight visits of all maternity services in North East and North Cumbria (NENC)
- To review good practice and areas for improvement in maternity services
- To enable targeted support from the Integrated Care System (ICS), Local Maternity Neonatal System (LMNS) and regional team.

Key points

In 2017, the former Secretary of State for Health and Social Care instructed NHS England and Improvement (NHSE/I) to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at the Shrewsbury and Telford Hospitals NHS Trust. This was undertaken by Donna Ockenden and known as the Ockenden report.

The initial report was published December 2020, the final report was published March 2022. All Trusts undertaking maternity care were required to submit evidence for all of the 49 questions within the 7 Immediate Essential Actions, Workforce and Guidelines. This was analysed and reports released December 2021. Unfortunately, many of the findings in the report are not new and can be found in previous reports and publications.

The regional maternity teams have conducted Ockenden Insight Visits to review the current position against self-assessments undertaken by each provider, based on the initial report of December 2020.

This paper focuses on the main themes from recommendations and the support from the ICB and the LMNS to improve the current position.

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Risks and issues
• Compliance with the seven initial immediate and essential actions are improving across the NENC Integrated Care Board (ICB) with no red actions for any provider • The final report with the 16 immediate and essential actions have not been reviewed and will be assessed after the publication of the East Kent report • Maternity services remain a high risk for providers.
Assurances
• The external review has seen an improving compliance against the Ockenden review. All providers report the position to their public boards • The LMNS, maternity network is working with the regional team to identify the key areas of improvement for the next six months.
Recommendation/Action Required
To note the paper.

Sponsor/approving director	David Purdue, Executive Chief Nurse
Report author	David Purdue, Executive Chief Nurse

Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓
CA2: tackle inequalities in outcomes, experience and access	✓
CA3: Enhance productivity and value for money	✓
CA4: Help the NHS support broader social and economic development	✓

Relevant legal/statutory issues						
Note any relevant Acts, regulations, national guidelines etc						
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓

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Key implications	
Are additional resources required?	No.
Has there been/does there need to be appropriate clinical involvement?	Clinical involvement critical.
Has there been/does there need to be any patient and public involvement?	Maternity Voices Partnership.
Has there been/does there need to be partner and/or other stakeholder engagement?	Regional Maternity Team, Maternity Network and Neonatal Operational Delivery Networks.

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Ockenden Immediate Essential Actions Current Position

1. Introduction

The regional maternity team have undertaken a review of all eight of the ICB maternity units' self-assessment against the seven immediate and essential actions identified in the initial Ockenden Report. This paper identifies the current position of our maternity units, highlighting the key areas for support by the ICB, LMNS and regional maternity team.

2. Background

The former Secretary of State for Health and Social Care instructed NHS Improvement in 2017 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 report was conducted by Donna Ockenden and the initial report was published December 2020, with the final report published in March 2022.

All Trusts, with maternity services, were required to submit evidence for all of the 49 questions within the 7 Immediate Essential Actions, Workforce and Guidelines. This was analysed initially by the regional maternity team and reports released December in 2021. Provider Trusts were mandated to publish a standard maternity dashboard at each of their public Board meetings to highlight the progress against the seven actions.

Many of the findings in the report are not new and can be found in previous reports and publications.

3. Main Issue

The following table identifies the current overall position of the eight Trusts providing maternity services within NENC ICB from the initial assessment in December 2021 to the reassessment in August 2022.

Ockenden Interim report Immediate & Essential Actions	Evidence submitted			North East & North Cumbria Themes for improvement	Evidence rating (overall for IEA)			North East & North Cumbria Themes for improvement
	Met	Partial	Not met	December 2021	Met	Partial	Not met	August 2022
1: Enhanced Safety		8		**Qu 2** external opinion for intra uterine death (IUD),maternal death (MD) Neonatal brain injury & neonatal death (NND). **Qu 4** audit 100% perinatal	6	2		**Qu 1** the triumvirate meeting as a team with minutes and action logs. **Qu 2** external opinion for intra uterine death (IUD),maternal death

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				mortality review tool (PMRT) cases were reviewed to standard and had an external review.				(MD) Neonatal brain injury & neonatal death (NND). **Qu 4** Embedded audit of PMRT **Qu 5** Maternity Services Dataset is not always to the required standard.
2: Listening to Women & Families	**1**	**7**		**Qu 11** Non executive director (NED) requirements **Qu 14** Safety Champions requirements.	**5**	**3**		**Qu 11** Non executive director (NED) staff did not know them or their roles* **Qu 14** Safety Champions staff did not know them or their roles. **Qu 43** Embedding of coproduction *many organisations had challenges during the pandemic which impacted the ability of the NED to engage with maternity services
3: Staff training & working together	**1**	**7**		**Qu 17** where not meeting targets mitigations are in place. **Qu 19** no ring fenced monies for maternity; budget statements; evidence of spending and spend reports to LMNS	**7**	**1**		**Qu 17** Live drills including baby abduction drills **Qu 18** there was not consistent evidence of a day & night ward round, with MDT presence. **Qu 19** no ring fenced monies for maternity; budget statements; evidence of spending and spend reports to LMNS.
4: Managing complex pregnancies		**8**		**Qu 25** audit of complex needs and referral; no referral to maternal medicine centre. **Qu 26** SOP for named consultant and an audit plan	**4**	**4**		**Qu 25 & 26** audits of compliance are not being completed with an agreed timetable to repeat in line with the results.
5: Risk assessment throughout pregnancy	**1**	**7**		**Qu 30** how women are risk assessed for place of birth at every antenatal contact. **Qu 31** risk assessment for referral birth options clinics, personalised care and support plan (PCSP) and audit. **Qu 32** Risk Assessment undertaken at every visit and PCSPs and audit	**5**	**3**		**Qu 30** & **Qu 31** audits of compliance are not being completed with an agreed timetable to repeat in line with the results.
6: Monitoring fetal wellbeing		**8**		**Qu 34** leads completing incident reviews and investigations. **Qu 35** sufficient expertise, clinical supervision, interface with other units, lead reviews of adverse outcomes.	**7**	**1**		**Qu 35** Evidence of job descriptions or role expectations of consultant leads were not always available / shared
7: Informed consent		**8**		**Qu 39** information on choice and Maternity voice partnership (MVP) rag rating of website **Qu 41** pregnant women/people being part of decision making, the CQC survey action plan **Qu 44** the Trust website gap analysis and quality of information	**4**	**4**		**Qu 39 & Qu 40** information available and language used around choice including maternal choice for caesarean section; Maternity voice partnership (MVP) review of website and other resources. **Qu 41** & **Qu 42** audit of pregnant women participating equally and feeling that their choices were respected in all decision making processes about their care
Workforce		**8**		**Qu 45** six monthly review of clinical workforce.		**8**		**Qu 45** six monthly review of clinical workforce at Trust & LMNS Board. **Qu 49** Strengthening of midwifery leadership teams
Guidelines	**1**	**7**		**Qu 49** audit that guidelines are in date.	**6**	**2**		Qu 49 audit that guidelines are in date

3.1 The table identifies the significant improvement in the compliance against the seven immediate and essential standards. Three of the Trusts are fully compliant against all seven standards. The key standards which the need additional support are; informed consent and risk assessment through pregnancy.

3.2 Workforce remains at amber for all providers, which is a national issue. Work is being undertaken with the regional workforce team to review training numbers with our Higher Educational Institutions. A shortened post graduate midwifery

course is also being discussed with Health Education England. The recruitment of international midwives is underway in a number of Trusts but the pipeline for international midwives is not as strong as other registrants due to the training undertaken outside of the United Kingdom.

4. Key Themes

Following the reviews, a number of recommendations have been made. The strengthening of coproduction with the Maternity Voices Partnerships (MVP) and improving service user involvement. Improving audit compliance especially in relation to informed choice. Improving training compliance including live drills and baby abduction. The improvement of Board oversight of maternity services including the governance of Board to Ward visibility. A review of governance processes for closing the loop and identifying learning and how this is shared across the providers. Positively all of the eight providers have signed up to the use of a single digital end to end maternity system. This will assist in improving compliance against the audit and documentation requirements for the Ockenden actions.

Strong effective leadership, respectful culture and teamwork**:** NHSE have commissioned a leadership programme for the quadrumvirates and triumvirates to provide training for the most senior leaders in maternity. The six-month programme, open to all Trusts over the next two years, will support tools for effective leadership. In addition, work is being undertaken nationally around improving culture.

Adequately resourced governance teams and training facilitators to provide good governance: all providers have been signposted to the reinvigorated maternity self-assessment tool Version 6 2021, to benchmark against a nationally recommended adequately resourced governance structure.

The ICB will support the governance processes to ensure maternity services are ready for the introduction of the Patient Safety Incident Response Framework.

Optimal place of birth for extremely pre-term babies**:** continued collaboration with clinical networks, LMNS's, providers and service users to improve the proportion of babies under 27/40 born in NICU.

Provide a positive working environment for staff and promote supportive, open cultures that help staff do their job to the best of their ability: the region have a successful Professional Midwifery Advocate (PMA) forum. There is ongoing commitment from the regional team to support succession planning in this area.

Continue to learn from women/birthing people who use services: MVP involvement, adequate resource, and true co-production: the development of a Strategic MVP Group. Nationally agreed renumeration will enable our MVPs to support underserved communities most affected by inequity across our services. The NENC LNMS have prioritised awareness of informed consent and choice, following high level feedback from an MVP survey.

When deviation from safety standards are identified there needs to be prompt action to meet the standards to prevent poor outcomes and/or regulatory enforcement: the national team are establishing an independent advisory board for the final Ockenden report. A revised national delivery plan will be prepared autumn 2022 with a long-term plan refresh.

Celebrating success: Celebrating and Sharing Good Practice event planned Spring 2023.

The ICB has reviewed the current structures in place to support maternity services. The proposed plan is to realign the three main networks with the ICB executive chief nurse becoming the senior responsible officer for the LMNS and working jointly with the Maternity Network and Neonatal Operational Delivery Network. Bringing the three teams together to focus on improving outcomes.

5. Recommendations

The Board/Committee is asked to note the improvement in compliance against the seven Ockenden standards.

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