Staffordshire County Council

Local Members Interest
N/A

Health and Care Overview and Scrutiny Committee Monday 17 October 2022

Ockenden Report update

Recommendations

I recommend that:

a. Overview and Scrutiny Committee (OSC) receives and takes note of the content of the report – recognising progress towards improving maternity and neonatal services whilst also acknowledging the challenges maternity services are currently facing.

b. OSC receives a further update in January 2023 on the national and relevant local developments following the imminent publication of the East Kent Maternity report and subsequent recommendations

Report of Heather Johnstone: ICB Chief Nursing and Therapies officer

Summary

This paper provides a briefing to Staffordshire OSC following the publication of the Ockenden final report into maternity services and Shrewsbury and Telford NHS Trust Maternity services (March 2022).

It summarises the 15 immediate and essential actions (IEAs) which were recommended to Government following the review.

The OSC should note the significant amount of work undertaken by providers in order to implement the initial 7 immediate and essential actions following the interim report in 2020. Whilst there has been no mandate to implement the 15 actions from the 2022 report, each provider has undertaken benchmarking exercises and continue to develop improvement programmes around the themes in the report

The OSC should also note the continued pressures each maternity and neonatal service are currently facing due to the ongoing challenge of workforce gaps.

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Report

1. Background

1.1 On 30th March 2022, Donna Ockenden's final report following her independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Trust was published.

- In total 498 cases of stillbirths were reviewed and graded, the majority of which were between 2000-2019
- One in four of these were found to have major or significant concerns, and if managed appropriately could have had a different outcome
- 12 Maternal deaths were considered and concluded that none of these had received care in line with best practice and a Third of these may have been prevented

1.2 The report describes the failings suffered by families during their maternity care and makes 15 additional recommendations to add to the initial 7 following the interim report. The 15 recommendations have been themed under what are described as 4 key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

1.3 The immediate essential actions (IEA's) are collated in chapter 15 of the report and the narrative endorses the latest Health and Social Care committee report 'The safety of maternity services in England' (2021) where a number of actions, such as increasing maternity funding and ring fence training budgets, have already been enacted. Each of the actions has a number of 'must be dones' and makes the overarching recommendation to Government that it should commission a working group, independent to the maternity transformation board, that has joint RCM and RCOG leadership. This group would guide the maternity transformation programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

Action 1:	Workforce planning and sustainability
Action 2:	Safe staffing
Action 3:	Escalation and accountability
Action 4:	Clinical governance and leadership
Action 5:	Clinical governance – incident investigations and complaints
Action 6:	Learning from maternal deaths
Action 7:	Multidisciplinary training
Action 8:	Complex antenatal care
Action 9:	Preterm births
Action 10:	Labour and birth
Action 11:	Obstetric anaesthesia
Action 12:	Postnatal care
Action 13:	Bereavement care
Action 14:	Neonatal care
Action 15:	Supporting families

The following links take the reader to the full report and also the press conference held by Donna Ockenden and is worth watching.

OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk)
Ockenden Maternity Review - Findings, Conclusions and Essential Actions - YouTube

2. Action required to date

2.1 On April 1st ICS, CCG, LMNS and Trust leads received a letter from the NHS Chief Executive, Chief Nursing Officer and National Medical Director with a strong recommendation that everyone, regardless of their role, reads the report. The letter also stipulates some specific actions to be taken:

1. Every Trust board is to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events
2. A dedicated maternity listening event should take place in the coming months.
3. Staff in maternity services may need additional health and wellbeing support.
4. Local action needs to be taken to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.
5. This includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)
6. In line with the maternity transformation programme, trusts were asked to submit their MCoC plans by 15 June 2022. In doing so, they were advised that they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts were therefore required to immediately assess their staffing position and make one of the following decisions for their maternity service:

    a. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
    b. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
    c. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

7. Boards must assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken and necessary assurance of implementation is in place.
8. Maternity services should discuss their progress with the seven EIAs in the interim Ockenden report before the end of March (i.e. immediately at the time of

publication) and discuss their position with their LMNS and return to regional teams by 15/4/22.
9. Trusts must also provide reliable data in the provider workforce return with executive level oversight.

2.2 It is important to note that there has been no mandate to act on the 15 essential actions from the 2022 report. Some of these recommendations require a coordinated response to implementation to ensure safety e.g. centralised monitoring.

2.3 The report into maternity services in East Kent is due for publication on 18th October 2022 following which it is anticipated that NHSE National Maternity team will issue a revised improvement framework to include all of the safety recommendations from each report

3. Current LMNS position as at 10/10/2022

3.1 The LMNS board receives monthly updates verbally and formally every quarter on progress against the 7 IEA's of which there are 45 sub categories.
3.2 Each maternity provider has submitted returns to NHSE demonstrating their compliance against the actions.
3.3 The NHSE regional maternity team, in partnership with the LMNS, have also undertaken an insight visit at each Maternity and Neonatal service provider to review the progress against 7 IEA submissions.
3.4 UHNM have received their report following this visit and are developing an action plan.
3.5 At the time of writing, UHDB have yet to receive their final report.

4. Points for celebration

1. Each of our local maternity and neonatal providers have undertaken a significant amount of work to improve their governance processes to ensure the line of sight from floor to board is clearer. For example: UHNM have developed an assurance map.
2. The executive teams at our providers have a much better understanding of maternity and neonatal services and are able to articulate the challenges and risks.
3. All of our maternity services have examples of innovative approaches to improving recruitment and retention for example, international recruitment.
4. UHDB have been able to maintain one of their continuity of carer teams in Burton.

5. Points for concern

1. Significant workforce gaps continue to impact on the ability to provide a full service as follows:

    - FMBUs are closed with no confirmed date for opening in either unit.
    - Continuity of carer teams at UHNM are suspended (in line with Ockenden recommendations and the subsequent letter to systems).
    - Home births are being intermittently suspended.
    - The co-located midwifery led unit at Stoke is also intermittently suspended in order to accommodate inductions of labour within the space.

2. Full compliance with consultant ward rounds on delivery suites twice daily 7 days per week is still a challenge to achieve in both UHDB and UHNM
3. Responding to high profile national cases such as those detailed in this report requires multi-professional collaboration and partnership and it is anticipated that Trusts will need to consider their organisational development requirements to ensure a proactive approach to improving culture.

Link to Strategic Plan

The Staffordshire and Stoke-on-Tent Integrated Care System (ICS) has an agreed vision: Working with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work:

Our purpose

- If you live in Staffordshire or Stoke-on-Trent your children will have the best possible start in life and will start school ready to learn.
- Through local services we will help you to live independently and stay well for longer.
- When you need help, you will receive joined up, timely and accessible care, which will be the best that we can provide.

Link to Other Overview and Scrutiny Activity

N/A

Community Impact

N/A

List of Background Documents/Appendices:

See links within body of report.

Contact Details

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